STORAGE

Vol. V. MAY, 1905 No. 2

DETROIT MEDICAL JOURNAL

The Practitioner's Monthly

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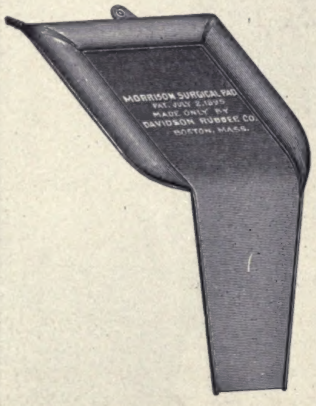

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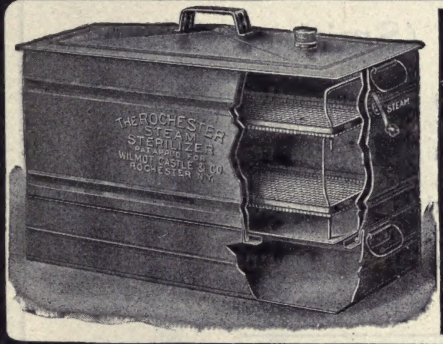

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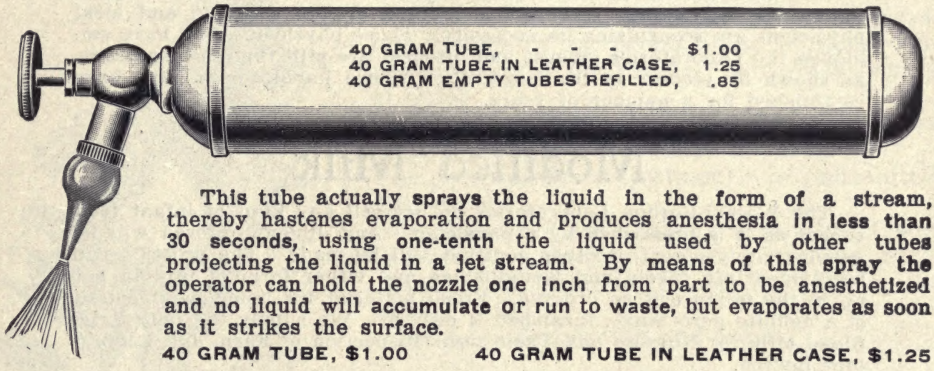

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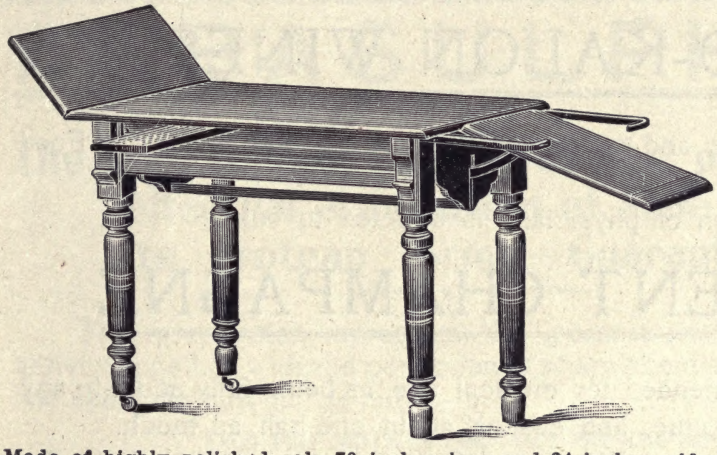

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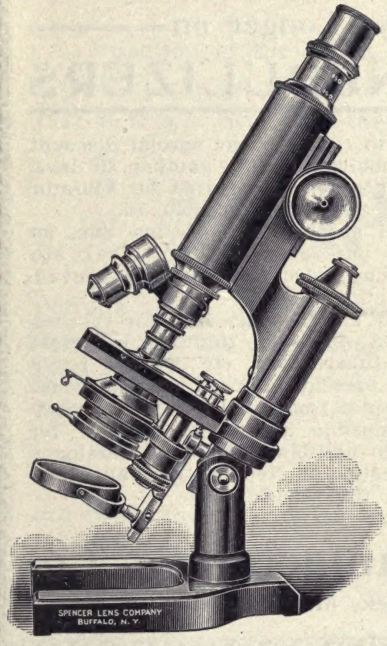

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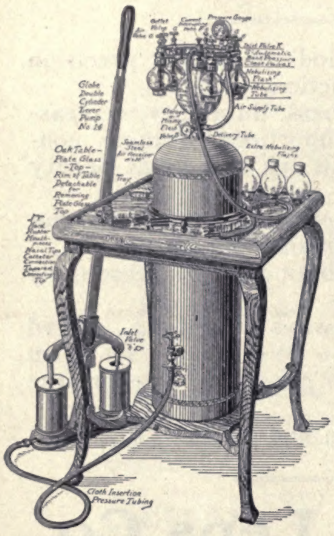

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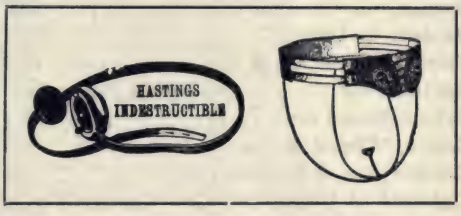

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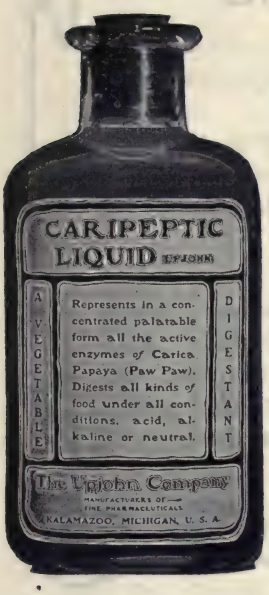
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THE DETROIT MEDICAL JOURNAL.

VOL. V. MAY, 1905. NO. 2.

SANITATION ON THE ISTHMUS OF PANAMA.

COL. W. C. GORGAS, M. D.,
Chief Sanitary Officer, Isthmian Canal Zone.

The great loss of life in the construction of the railroad, and the effort of the De Lessepps Company to build the Canal, were due principally to malarial and yellow fever; and it is to these two diseases that the Sanitary Department has principally directed its attention.

I will not attempt to describe the country through which the Canal runs, or its location; these are sufficiently well-known from the public discussion of the matter in the daily papers, journals and magazines. It is sufficient to say that it runs through a rolling and well-watered country, with not more marsh than would occur in a similar country in the United States. Physically there is nothing very unusual or very difficult as to its sanitation.

At the time of the commencement of the work by the Sanitary Department, in June, 1904, the country controlled by that department had a population of about 40,000; 20,000 in Panama, 10,000 along the Canal between Panama and Colon, and about 10,000 in Colon. The main object of sanitation was to free this territory from yellow fever, and as much as possible from malaria; and when free, to prevent a re-introduction from the outside, of these diseases.

With regard to yellow fever, it was looked upon as entirely practicable to accomplish both objects, that is:—to get the country free of yellow fever, and when once free to prevent its re-introduction. Both these objects had been accomplished at Havana, and there was no reason why we could not do the same throughout the Strip.

With regard to malaria fever, we hardly thought its entire extermination in the Strip possible; or, if this were effected, did we think it possible to prevent entirely its introduction from the outside. But we do not consider this necessary for its practical control, our hope being so greatly to decrease it that it would not be an abnormal factor in the health of our employees. Such a reduction as occurred at Havana, in malarial fever, would meet all practical purposes.

I will first consider the measures thought necessary for the control of yellow fever. At the time of our arrival the city of Panama was the only point on the Strip infected by this disease. Here it was recommended to establish a regular health department, which should clean the streets, collect garbage, dispose of night-soil, and do mosquito work. By treaty we had agreed to put in a sewage and water system. By

these measures we felt sure that yellow fever would be eradicated from Panama. For the control of malarial fever it was recommended that at the twenty or more little towns along the Canal, mosquito work, for the destruction of anopheles, be undertaken, just as at Panama; but it was advised that the greatest expenditure be made in the direction of anopheles brigades, for doing superficial draining in the towns and in their neighborhood, all along the line. It was also planned to commence a vigorous campaign against malaria among those affected, by the free administration of quinine.

For the purpose of keeping out yellow fever after the Zone had once become free, it was recommended that an efficient quarantine be established.

We have now been working eight months on these lines, and I would like to point out what has been accomplished. It must be remembered that all supplies have to be gotten from the United States; that we are a long way from our base and it is very difficult to get these supplies. That we are at the beginning of a great undertaking, and that the organization is at first necessarily slow; so that we have encountered great and unexpected difficulties in all these directions. We have at present in Panama an efficient health service, with some 200 employees. We are cleaning the streets, caring for the garbage, have made mosquito-proof every water barrel in the city; regularly oiled all the tanks, and in the suburbs oiled the marshy lands that cannot be easily drained. Every case of yellow fever that has occurred was fumigated with pyrethrum or sulphur as the circumstances demanded. The point at which it occurred was looked upon as a focus, and the house and contiguous houses had all the mosquitoes in them destroyed by fumigation, as was done in Havana. Within the last month, with a view of more rapidly controlling yellow fever, a general fumigation of the town has been undertaken; that is:—the city is being gone over systematically with the idea of destroying mosquitoes all through the city irrespective of where cases occur. We have had since June less than forty cases of yellow fever in the whole population.

The water supply and sewage system are well under way, and, unless unexpected delay should occur, will be in operation by July of 1905. Panama is favorably situated for drainage and health, and when the water and sewage systems are in we will prohibit all water containers of any magnitude, such as barrels, cisterns and wells; and I am confident that in this way we can do away with mosquitoes and thus hold in check both diseases,—yellow fever and malaria.

Along the line of the Canal we have established sanitary work, at the twelve or fifteen towns at which laborers are at present stationed. We look after their cleanliness, and have done a great deal of superficial drainage; and have obtained good reports of the morbidity and mortality rates. We have some 250 laborers engaged in this work.

At Colon, which is situated on an island made up mostly of marsh, we have also established a health department; but it is hardly practicable to do effective mosquito work until the island has been filled in. We have not pushed matters so much here. It is planned to fill in the entire

island on which Colon is situated, with the material taken from the Canal in its neighborhood. This, the Chief Engineer tells me, he thinks will be accomplished by the end of the present year. Colon so far has shown very little evidence of being infected with yellow fever.

For the care of the sick, we have established hospitals at Ancon, in the suburbs of the city of Panama, at Colon and at three points along the line. We also have an establishment on the mountainous island of Taboga, out in the Bay of Panama. In these hospitals we have at present about 250 patients. With the buildings already authorized by the Commission, their capacity could be brought up to a thousand beds, which we hope to have completed by July, 1905.

With the object of controlling the introduction of disease from the outside, we have established and have in excellent working order, quarantine systems at both Panama and Colon.

The sanitary results so far obtained have been excellent,—if measured by the health of the force under our control. On the 1st of February the Commission had present on the Isthmus over 7,000 employees; and of these employees only about 115 were in hospitals. This would be an excellent rate for the same number of men in any part of the United States; and if the same standing can be kept up the Sanitary Department will be more than satisfied. We have at the present time a few over 1,000 men doing sanitary work in the territory under the control of our Government.

Ancon, Isthmian Canal Zone.

THE BORDER LINE BETWEEN OPHTHALMOLOGY AND GENERAL MEDICINE.*

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Fort Wayne, Indiana.

This subject has not been of my own choosing and while I fain would have relegated its treatment to an abler exponent perhaps what I shall leave unsaid will prove to be the interesting portions upon which an active discussion may be had.

By this we mean to ask the ophthalmologist where, in his judgment, the care of cases of eye troubles ceases as to the general practitioner and becomes subject to himself, and on the other hand, where the pathologic conditions of the patient ceases as to the eye, and becomes subject of interest only to the general practitioner. This is a question of retro-action and must be viewed from the different positions of those interested.

It may be viewed abstractly in which case the patient's best interests alone must be considered. It would thus seem that the abstract view would include all other views. But what is right may be considered from a practical standpoint as well as from an ethical basis. The boundary line between meum and teum are extremely uncertain

*Read before the Northern Tri-State Medical Society, Toledo, Ohio, January, 1905.

when the dollar lies hidden in the borders. There are many factors entering into each individual's action in surrendering a case, which make it a complex proposition and we must sympathize with a physician and try to place ourselves in his coign of vantage before criticising his action in withholding a patient from the specialist for a time. We must not forget that we are so constituted that we bear our neighbor's troubles with heroic fortitude and that we can determine with precision what is the right thing for the other man to do. Job had his comforters, but Job had reminded them that they did not have any boils. Again, the final analysis of this question may be summed up by asserting that the patient's highest good must be sought. In practice again the patient's highest good is relative. Individual equations will cut a large figure. The general practitioner may have been educated at a time when little attention was devoted to diseases of the eye and he therefore posesses but a rudimentary knowledge of such diseases. He may not place a high value upon an eye or may be imbued with the traditional fallacy of the laity that the loss of one eye will strengthen the other. The patient's environment counts heavily in the disposition of the case. If the patient is intelligent and alert to his surroundings he will determine for himself what is best for his own good and will demand an ophthalmogist. He may do this merely as a matter of obtaining a diagnosis. The politic physician will never refuse this and will in most cases concur. In injuries especially such acquiescence on the part of the attending physician may save a suit for damages. Again the patient may be so situated financially that he is unable to discharge the most necessary expenses of travel, let alone paying the ophthalmologist for his time. I believe that the average family physician tries to eliminate self in the disposal of his eye cases and that the family physician who attempts to treat eye cases is fast becoming obsolete.

Mr. President, a new danger, however, is arising and one which promises quite as serious consequences to the patient as the one which the merciful erasures of time is slowly wiping out. The danger which is ubiquitious and omnipresent, is the peripateic and stationary "doctor of refraction," supported and encouraged by the well equipped general practitioner. This is a new species which as yet has not been classified and has no definite place in scientific nomenclature. He would probably prefer the cognomen of "doctor of refraction," yet is not averse to "scientific refractionist," and will acknowledge the soft impeachment if you call him "expert optician," and if you have the price he will come if you just say "specs." But, whatever you call him, he is here and must be reckoned with for he is doing harm. He knows no medicine, anatomy, physiology, or the therapeutic application of glasses and although he calls himself the "scientific optician," with the exception that he is neither scientific nor an optician, his self imposed title is correct. A blacksmith may with more right claim the title of orthopaedic surgeon or a plumber that of genito-urinary surgeon, than the spectacle misfitter the title "expert optician." It is by no means an isolated example to have the family physician advise his patient to consult Mr. So and So, or "Doctor" Ditto,

and have him furnish a pair of glasses. You see the doctor has been to the county society and heard eye strain discussed in a paper of some length. But the paper did not and could not illustrate the entire chapter of reflex phenomena and hence the doctor only caught a straggling ray of light and used it to his own and to his patient's detriment. The patient procured the glasses. He wore them three weeks while his eye symptoms grew worse. He consulted the writer. Diagnosis: specific choroiditis. Result after four months' treatment; right eye lost 6-10 of sight; left eye lost 1-3 of sight and the physician lost the family. The patient said that the doctor did not know in that case and was not honest and he may not in the same manner in other cases.

The relation of a large majority of diseases of the eye to the general system is so intimate that the proper treatment of the one involves a full knowledge of the other. Let us take for example albuminuric retinitis. The family physician may have made out a diagnosis or he may not and owing to a small hemorrhage in which the vision has been obscured the ophthalmologist is consulted. He not only makes a diagnosis, but also hands down a prognosis in which he informs the friends that not only will the patient die, but that he will die within a period of six to twelve months, and that nothing can save him. Here is clearly the duty of the ophthalmologist to refer the case back to the family physician with the diagnosis and prognosis in accordance with the facts. In case the family physician has not been consulted the ophthalmologist should inquire who the family physician is and confer with him.

Many ophthalmologists make the serious blunder of recommending a physician to his patient in whom he is interested, and overlooking the family physician.

This is very impolitic because it estranges the family physician from him and makes them look upon each other with suspicion. Again in the secondary manifestations of syphilis involving the eye in which the case has been under the care of the general practitioner, how shall we demean ourselves toward the patient? We well understand that here mercury is our sheet anchor with which to combat the general condition and that it must be pushed to the limit, and that, too, in a rapid and fulminating manner, so as to permit of the least harm to the structures of the eye. At the same time the local conditions which threaten the function of the eye must be met and the action must be swift and treatment may vary within twenty-four hours, or even within a shorter interval. I prefer in such cases to have a free hand in the treatment of the patient as long as the eye symptoms are present, and as soon as they have subsided the patient must be promptly referred back to the family physician with the request of an occasional examination of the eye. In fact, in my mind the whole question is a simple one, and where the family physician and the ophthalmologist are honest with themselves there need be no conflict of medical interest.

The writer frequently has cases referred to him with the request that a diagnosis be made and a line of treatment suggested which will enable the family physician to carry on the treatment of the case at

home. Here is a complex question in which several conflicting interests figure. First, you are requested to open a clinic in which you take all the responsibilities of a case without adequate compensation. Secondly, you discuss the pathology of a case with one who has not full conception of the variations possible in such cases. Thirdly, you offer information which is accepted as general and application is made of this information at a subsequent period in a supposedly similar case when much harm results from a misconception of conditions.

Again, to quote your late fellow townsman, the immortal Josh Billings, "it is better not to know so much than to know so many things that aint so."

Some spectacular enthusiasts in the profession have unconsciously applied the faith cure to a large number of neurotic conditions and reached the pyschic centre through the medium of glasses. In this manner many a gynæcologist has been saved the pains of an hysterectomy or ovariotomy; many a physician has avoided the labor of a daily lavage of the stomach; many a neurologist has been spared the annoyance of administering the rest cure to a neurasthenic, and that a valuable quid pro quo may be handed the ophthalmologist the doctor now suggests to the patient with nervous symptoms of undefined origin that he should have his or her eyes examined for glasses. He draws our fangs at one fell swoop and when serious refractional and muscular errors are found and remedied the neurotic symptoms pass away. We do not know whether to feel grateful to the physician or chagrined that he has referred his patient to us as a mere optician. If the request would come "please examine So and So's eyes and tell me, if in your judgment, there is any relation between the existing eye anomalies, if any exist, and the symptoms from which my patient suffer. Here we arise to the dignity of a consultant while if we are asked to examine this patient and determine if he needs glasses we are simply in the same category as the physician's assistant to whom he hands a specimen of urine and asks him to determ its constituent parts.

A serious error, on the part of the general practitioner, consists in his making a diagnosis or prognosis in the case which he refers to the ophthalmologist. The pathological condition very often does not warrant a concurrence in the diagnosis made, much less in the prognosis and the ophthalmologist must either gloss over the statement made by the family physician or he must protect himself and give the true condition. This may be humiliating to the family physician and it is always unpleasant for the ophthalmologist, while it gives the patient an opportunity to make injurious statements if he is so inclined.

Atropine and eserine are not drugs simply with pretty names. They have a wide circle of use and their application is definite. Hence, they should never be used except by the physician who fully understands their action and application.

That large class of cases which comes definitely under injury of the eye and includes incisions, lacerations and concussion of the retina, and rupture of the choroid should always be under the care of the ophthal-

mologist and the sooner they are referred to him the better for all concerned. It serves no useful purpose to speculate on what nature may do in an incised cornea with protruding iris. You may as well speculate on what time will do in strangulated hernia or intussusception of the bowels.

Gonorrheal ophthalmia in the adult, as well as in the new born, demands prompt and intelligent action and the case is lost or saved within the first thirty-six hours in the adult and within the first seventy-two hours in the babe. Don't wait in these cases. Call the ophthalmologist.

Mr. President, manifestly nothing more than a mere indication of one's duty can be set forth in a paper of this character. To the physician who desires to do the right thing by his patient, statutory laws are unnecessary, and to the man who does not want to do the right thing by his patient the spirit of ethical law is not sufficiently catholic to cover even a small part of the rules of practice. The constant evolution of the masses, the transition from a lower to a higher level plane of development of our intellectual and moral forces, together with the growth of our physical being, will eventually simplify the ethics of life into the Talmudic formula, "Do not to another what you would not have another do to you."

NOSE AND THROAT WORK FOR THE GENERAL PRACTITIONER.*

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The development of specialism has made such progress in the last decade that it would seem timely to consider some of the problems of nose and throat work that confront the general practitioner in his efforts to supply his patients with the best treatment that circumstances and the environment afford. The opinions offered are based entirely upon an active experience in general and special practice of some years, the latter part devoted almost exclusively to the nose, throat and chest.

The profession is suffering at the present from an over production of ready-made specialists, who immediately following graduation and after completing a few months in a post-graduate school, blossom into specialism. An interesting question arises at this juncture. What qualifications constitute a specialist? How may the general practitioner recognize him as such? Let us define him as the physician and surgeon who first, by special aptitude, and later thorough liberal and special scientific education, including post-graduate study and at least five years in the school of general and hospital practice, has so trained his faculties that his skill and dexterity along his chosen lines call for recognition. With these qualifications he might be registered with the state society as competent for expert work along certain lines, or an amendment might be proposed to our medical laws requiring a minimum of five years active general or general hospital practice, and an examination be required before the candidate is entitled to recognition.

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In this way we may hope to establish specialism on a more dignified and more respectable basis. The ideal physician or surgeon with practice limited, has become such because his opportunities, his talents, his scientific preparation, and his natural inclinations have become recognized by his fellow practitioners, and patients and his general practice has gone through such a process of evolution that his special work demands his entire time. With this introduction let me proceed to the topic assigned to me. A consideration of the subject demands three distinct sub-classifications. First, what nose and throat cases are exclusively for the care of the general practitioner?

Second, what are border line cases?

Third, what are strictly cases that should be under the care of the laryngologist or rhinologist?

The physician and surgeon in general practice is peculiarly skilled in a knowledge of acute manifestations of the nose and throat attending general conditions. He knows that a diagnosis of acute disease in infants and children is incomplete and unscientific without a careful examination of the throat. He recognizes, as no specialist can without a similar training, that the throat is the key to the problem in more than one-half of the acute infections in children. The early stages of tonsillitis, quinsy, diphtheria, scarlatina, measles, influenza, stomatitis, small-pox, chicken-pox, and erysipelas are familiar throat pictures to him. If he appreciates the full significance of his responsibilities, he keeps ever prominent in his mind the medical principles involved, viz., that the nasal, naso-pharyngeal or pharyngeal mucosa has become a culture medium for the development of toxins. The battle is waged locally to prevent systemic absorption by thorough irrigation of the nose, naso-pharynx and throat with normal saline solutions and antiseptics.

The various chains of lymphatics are observed with anxiety, and we frequently grade our prognosis in the exanthemata upon the degree of absorption from the lymphoid ring. In other words, an acute infection engrafted upon chronic hypertrophied or otherwise diseased faucial tonsil and adenoids is attended by an increased number of complications and higher mortality. This is especially true of scarlet fever and diphtheria. It is eminently the nose and throat work of the family physician to remove all diseased tonsils and adenoids. The dangers of this condition are so real and so prevalent, and the results of operation are so satisfactory that no case should be overlooked.

The medicinal sheet anchors of the laryngologist are those of the general practitioner, viz., silver, iodine and carbolic acid and their compounds. Their use in many moderate cases is attended by very satisfactory results, and they deserve the prominent place their action has given them.

Adrenalin chloride takes rank with antitoxin as a marvelous discovery of the decade. Its well known use as a spray or application to prevent post-operative hemorrhage or acute intumesence is exceedingly satisfactory.

The days of ultra radical nasal surgery, when no patient was allowed

to retain a spur, have happily passed, and the interesting question confronts us—what surgery should the general practitioner be qualified to undertake? In addition to the required knowledge of general surgery of the external nose and mouth, he should be capable at least of performing ordinary uvulotomy, tonsillotomy, adenotomy and tracheotomy, and cauterizing the anterior end of the inferior turbinates for intumescent rhinitis. Those with special aptitude or special instruction should be able to remove simple spurs and anterior hypertrophies, or do other simple turbinectomies, and possibly perform the Asch septum operation. Intubation should be mastered by at least one individual to every district of twenty physicians and the work turned over to him. On account of its especially contagious and septic character, general surgery and obstetrics must be avoided until thorough disinfection can be established for the operator. Quinsy falls into the hands of the specialist only when the family physician has neglected to relieve the pain. This may be done by douches of hot water containing borax and boric acid, allowed to run from the nozzle of a fountain syringe directly against the tonsil, until free incision can be made at the hardest point. This should be determined by digital examination. Retro-pharyngeal abscess may be opened with the finger nail.

The specialist is expected to master every operative procedure within his chosen field. The intricate and complex problems that have become a burden to the family physician are especially pleasing to him. Chronic laryngeal conditions of all varieties, radical operations on the accessory sinuses, the removal of posterior hypertrophies and various operations for deflection of the septum occupy his special attention in the nose. Tumors of the nose, naso-pharynx and pharynx, thyrotomies, laryngotomies and laryngectomies, the removal of foreign bodies, intubation of adults in addition to those operations already enumerated, are of peculiar interest to the qualified specialist. The laryngologist and family physician meet the border line cases most frequently in the differential diagnosis of tonsillitis, diphtheria and syphilis. To whom do these patients belong? Legitimately to the first consultant. Conditions only can determine and the specialist has the opportunity of referring the individual to the family physician for general treatment.

In the capacity of laryngologist of the Poor Commission and Board of Health, and in the contagious wards at Harper Hospital a large number of these cases have come under my observation. Errors and delay in diagnosis seem more frequent than necessary. This is especially true of tonsillitis and diphtheria. The city physician who has laboratory facilities can employ the culture method and at least shift his responsibility to the bacteriologist. The clinical picture to the well trained eye is usually all sufficient. True, there are a number of border line cases of the lacunar variety that are impossible to diagnose in the first 24 hours. It is our duty to express frankly to the patient that we do not know and not acquire a reputation for curing diphtheria in two days. There are certain definite phenomena, however, which are of great value in forming an opinion. The tonsillar diphtheria exudate develops a character-

istic grayish appearance and is firmly fixed upon the mucous membrane. The soda solution does not remove it and any detachment of the pseudo-membrane is attended by hemorrhage. The lines of demarcation are ragged and the adjacent mucosa into which it sets like a watch crystal is increasingly red and swollen. A tiny film may soon form on the uvula or another point of extension may be detected along the anterior pillar. A chill, fever and pain in the throat of no diagnostic significance, are a familiar onset. This picture is so certainly diphtheria that 2,000 units of antitoxin should be administered without awaiting further developments. This line of therapy is absolutely and immediately necessary, if the child is of croup age and the additional symptoms of hoarseness have developed. Intubation will never be required when proper treatment has been given.

In conclusion, let us urge the general practitioner to always examine the throat, to become more deeply interested in this line of work, to at least more thoroughly master its many simple minor operations, and bring about the splendid results that nasal drainage and God's pure air give to the human system. May he look upon the specialist as a man with a legitimate function and a friend in need.

SOME POINTS ON RETENTION OF URINE.

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Detroit.

The terms "retention" and "incontinence" are so often used indiscriminately by physicians, that a few words of explanation may not be amiss.

Incontinence of urine, or enuresis, is that condition in which the urine flows involuntarily out of the bladder as soon as it flows in. Incontinence must be distinguished from overflow; in both cases there is a continual, involuntarily dribbling, but in the first the bladder is empty and in the second, the bladder is full. Enuresis shows that the bladder leaks; overflow shows that the outflow pipe is obstructed. In the adult male, dribbling of urine nearly always means an overflow. In true incontinence, the urine flows away without any pain or desire to urinate. Imperative urination, when the inflamed bladder contracts every few minutes with a force that the cut-off muscle cannot oppose, is often spoken of as false incontinence.

When after an attempt at urination, a certain amount of urine remains in the bladder, there is said to be partial retention of urine. If no urine at all can be passed, the bladder being full, there is complete retention.

In childhood, incontinence of urine is troublesome and is usually due to imperfect development of the closure apparatus of the bladder. This often disappears about 3rd year but sometimes persists up to puberty. The condition is often improved by the use of atropine or atropine and strychnine or bromide of camphor, with proper hygienic care.

In retention in an adult, the bladder may be full and the urine dribbling away without the patient's knowledge; the knee-reflex should always be tried in such a case, which may be one of Locomotor Ataxia or some dis-

ease of the spinal cord. Complete impotence usually accompanies retention.

Stricture of the urethra may be the cause of retention or the patient may have a distended bladder and an overflow from an enlarged prostate, other causes are congenital tightness of the prepuce or meatus, stone, spasm, tumor, etc. Keys states that 95 per cent. of all cases of retention of urine are due to urethral stricture, to contracture of neck of the bladder and to prostatic hypertrophy.

Effect Upon the Bladder.—The first effect is a straining of the bladder muscles, resulting in a congestion.—In trying to overcome the obstruction, the bladder undergoes hypertrophy and residual urine collects. Bacteria thrive in the residual urine and begin to work at the congested bladder wall, producing a cystitis. The bacteria are not the most dangerous thing in the urinary tract unless a suitable soil exist for their growth. A healthy bladder usually disposes quickly of the bacteria. By avoiding trauma inflammation is prevented and by relieving retention, the inflammation may be cured. The cystitis in cases of stricture or of hypertrophied prostate is nearly always started by instruments and perpetuated by retention.

Effect Upon the Kidneys.—In these cases of stricture and prostate with retention, the urinary pressure increases gradually for weeks or months. As a rule there is little or no distention of the ureters or kidneys until complete retention results. But before this time a chronic congestion is going on in the ureters and kidneys, while in the kidney, the sclerosis resulting from a long continued congestion takes the form of a chronic nephritis. Some of the excreting epithelium is destroyed and the remainder is forced to excessive work by this loss. When the kidneys become congested, then they are apt to be bacterially inflamed. The bacillus coli may infect the kidney in its early stage of congestion, but it is not attacked by the bacteria of ammoniacal cystitis, until it provides a pocket or nook for their growth.

Clinically, we see cases of severe ammoniacal cystitis complicated by pyelo-nepthritis, but acid pyelo-nephritis of a mild form. Sometimes the opposite is seen, i. e., a suppurating, pouched broken-down kidney pouring its swarm of bacteria through a bladder, which is affected little, or not at all, because it is fully able to empty itself.

Treatment.—When retention is due to stricture of the urethra, the stricture must be overcome by dilatation or cutting. In most cases, gradual dilatation is the best treatment. Internal urethrotomy is indicated when the stricture is near the meatus. External urethrotomy is quite safe, the chief danger being sepsis, if the kidneys are diseased. If there be extravasation of urine into the perineum, then an external urethrotomy is indicated.

In cases of impassable stricture, the commonest site is in front of the triangular ligament. Bank's bougie is used, first injecting the urethra with oil. Then a larger bougie is used, until a small sound can be passed and the stricture dilated. The urethra should be made as aseptic as possible . When the tip of a small bougie goes through, then you are master of the situation. It is difficult to get one in, if there are false passages. If you fail to get anything through the urethra, then use a trochar and canula above the pubes. A small Nelaton catheter is passed, through the canula, deeply into the bladder; the canula is withdrawn and the catheter fixed in position by ad-

hesive straps and safety pins. The urine escapes through this catheter for 3 to 4 days, when the false passages are healed. Then a Bank's bougie can usually be inserted through the urethra, after which the suprapubic catheter is withdrawn and the puncture heals readily, provided the bladder is drained.

SHOULD WE HAVE COUNTY HEALTH OFFICERS?*

By F. E. KITZMILLER, M. D.
Piqua, Ohio.

I am invited to read a paper today upon, "Should We Have County Health Officers?" We have in this a question of very great importance. —There is no question in my mind but that the health department of state, city, town, village or township, is the most important of all departments, and properly administered, saves many lives, much suffering and protects the business of the people.—What other officials in the state do such great good and in return receive so few thanks, so little money, and so much abuse?

The successful fight against contagious disease requires the strict enforcement of quarantine laws, along with the other rules and regulations of the State Boards of Health. This result can only be obtained by the most complete and thorough organization; and it is poor policy for any community to be brought face to face with a contagious disease and find themselves without organization according to laws of the State of Ohio.

In order to consider the question of "county health officers," we should make some investigation as to the organization of health boards and the appointment of health officials, especially in the small towns and out-lying townships. Is it not a fact that this has been neglected in many instances?—It matters not how diligent our State Board may be, they are depending upon local boards of health to do their duty and effect proper quarantine in the first case of contagious disease, and thus prevent an epidemic.

Is it not a fact that small-pox has become epidemic in many localities by lack of proper action upon the part of township trustees, who are under the law, a board of health?

Is it not a fact that many towns and townships are now and have been for a long time without any board of health organization or health

Early the past summer I found a town of 500 population located about twenty miles north of our city, in a state of excitement and indignation; mainly caused by lack of organization and health officials. It was reported to me early one Monday morning that four young people of our city had spent Sunday at a house in this town where a child was sick: I was told that the child had some kind of aneruption. I at once sent for the Piqua people and vaccinated them, being very suspicious from their report of the case.

I then took a traction car and visited the town. I at once called upon officer?

*Read before the annual meeting of Health Officials, of Ohio, January, 1905.

the mayor who received me with open arms, especially when he found I had my small-pox outfit with me, and was willing and even anxious to go and examine the patient. This town had no board of health or health officer, so the mayor had ordered the town marshal to card the house upon the report of one physician who, believed the child had small-pox. Another physician claimed it to be chicken-pox. The citizens, as they generally do, took the side of the chicken-pox doctor, and openly denounced the mayor for trying to quarantine the family and injure the business of the town.

On the way from the mayor's office to the house of the patient, the mayor told me how the people felt and how uncomfortably warm they were making it for him.

Strangers, as you know, attract attention in small towns, so by the time we reached the house, quite a few people were following us. During the time I was in the house a few others arrived. After my examination I changed my clothing, and after disinfecting my hands and face, walked up to the people. The mayor at once asked for my opinion of the case. I answered by first explaining my position and the cause of my visit, stating plainly that I was not in any way interested in their town or their people, and I was there simply in order to protect the citizens of my own city, whose people had been exposed at this house. I then stated that I found the child, the suspected case, a well marked case of discrete small-pox, and that the mother was just showing the appearance of the disease, and advised them to keep up a strict quarantine and have everybody vaccinated. Owing to the unpleasant condition of affairs I found they had no attending physician. I gave the mayor a prescription to relieve the child's itching which was sent to the house at once by the druggist, and a doctor was procured next day.

In spite of precautions taken after this time the disease spread, becoming quite an epidemic, and the people had an experience they will not soon forget.

There are no doubt many other towns and country districts in Ohio where the people have sadly experienced the dreadful results of a want of organization and prompt enforcement of quarantine laws. Under the present laws every village, town, city and even township, is supposed to have health officials, but we find that in many places the law is not carried out. It is not the fault of our law, and its not the fault of our State Board as it is almost impossible to keep in touch with all the towns and townships in the State and know to a certainty, that they have a board of health organization and officers elected and ready to do their duty.

I have no doubt that there would be a greatly improved condition if the state board of health had an agent located in every county in the state in the person of a county health officer, giving this official direct charge of the whole county except large cities.

The county health officer should keep a record of all health officials in his county, and all cases of contagious diseases should be reported to him as well as the state board. He should go when called upon or when in his judgment or the judgment of the state board it may be advisable

for the purpose of giving instructions in proper quarantine or making a diagnosis in any case where the diagnosis is in question, and should promptly report to the state board all contagious diseases, also all carelessness discovered in the administration of health authorities having direct charge.

The enactment of a law creating a county health officer who would be a local agent of the state board of health, would, in my opinion, be a step in the advancement of Ohio's sanitary laws.

It would cause towns, villages and townships to be more prompt in the discharge of their duties. It would cause physicians to be more careful in their diagnosis.

There is no question but every health officer in the state should be a physician, and if possible, one of sufficient experience and judgement to take the safe side and give the people proper protection. All health laws have been created with the intention of protecting the people of the state against contagious diseases; yet the law fails to say whether the health officer shall be a blacksmith, a shoemaker, a laborer or a precinct politician; and it does look to me that the law should call for the seection of a physician.

While we are considering the present laws there is another weak place worth consideration. It is the provision in the law by which council may by ordinance dismiss the board of health provided for in the code; make the board of public service a board of health.

The code has given cities independent boards of health upon a non-partisan basis and the merit system is made possible.

The independent board of health is an important part of the city government and such boards are composed of good citizens serving without compensation and with only the good of the city at heart. Why remove them? why destroy the merit system? The people who pushed this special bill through the legislature could answer and state the number of axes they expected to grind upon this political grindstone.

Partisanship and public health matters are not compatible and the sooner all health department officials, state and local, are divorced from politics, the better it will be for the people of the state.

Should a law be enacted creating a county health officer, the selection of a proper man will be of very great importance. Important to all the physicians and health department officials of the county.—All the people of the country, as well as the state board of health, and we might say all the people of the state.

In the county health officer we should have a thoroughly competent physician, sober, conscientious and from experience able to make a diagnosis. He should be liberal enough to treat physicians of the several schools of medicine to the satisfaction of all; he should be always certain of giving the people protection without oppression and in all cases of doubt, take the safe side. There is no certainty that the doctor with the political pull will be found qualified for the position.
found qualified for the position.

In order to get away from the fellow with the political pull and from

others who are wholly incompetent, would it not be for the public good, for the doctors of the county to nominate one of their number as a candidate for county health officer, subject to the approval of the state board of health?

As stated before the county health officer would be the county agent of the state board and it would look like a good business proposition for the state board after proper investigation to finally make the appointment.

It does seem a difficult matter to separate the health department from politics but it is no less important that it be done.

In conclusion,, I wish to say that in view of the fact that much carelessness has existed in local health departments and among physicians, I have no doubt the appointment of county health officers would at once bring about good results. It would cause local health departments and physicians to be more prompt in the discharge of their duties, and prove of great assistance to the state board of health in the prevention of epidemics.

There are in every county nuisances such as slaughter houses, filthy dairies, etc., in which for various reasons local authorities hesitate in enforcing the law.

The county health officer could see to all this and prove himself a much needed and appreciated official.

CLINICAL REPORTS

A Case of Primary Carcinoma of the Fallopian Tube.

By BENJAMIN R. SCHENCK, M. D.,
Detroit, Mich.

Primary carcinoma of the fallopian tube is a rare affection. Since Orthmann's case,* which was reported in 1888 and was the first on record, a few instances have been recorded each year. In many of the earlier accounts, it is difficult to determine whether the cases were adenomata or true carcinomata and also whether the tubal tumor was primary or secondary to a cancer located elsewhere.

In 1901, Hurdon** sifted the cases and admitted thirty-five to the list of undoubted primary carcinomata. Since then, there have been five additional instances, making the total number of the authenticated cases about forty. My case was a typical one, conforming, in almost every detail to the text-book picture of the affection.

Mrs. M. H., aged 53 years, was brought by her physician to the Johns Hopkins Hospital, Baltimore, on June 16, 1902, to be treated for a small pelvic tumor, which he had discovered a few weeks previously.

Mrs. H. gave the following history:—She came from a family in which there was a tuberculous history, one sister having died of pulmonary tuberculosis, from which one brother was also suffering. There was no history of malignant trouble. Until the past two years, the patient had been remarkably strong and robust. She had been married 34 years and had had four

*Orthmann. Zeitsch. fuer Geb. u. Gyn. Bd. xv., 1888.
**Hurdon. Johns Hopkins Hosp. Bulletin, October, 1901.

children, the eldest of whom was 32, and the youngest 24 years of age. The labors and puerperia were normal. Menstruation, with which there were no disturbances, ceased at fifty years of age, the menopause having been passed without mishap.

The history of the present trouble seemed to date back two years, when the patient began to suffer with bearing down pains in the lower part of the abdomen, on the left side. There was no soreness or tenderness until three months before seeking relief, when both became marked. The pain also increased in severity. At about this time, a thin, blood-stained discharge began and this was very offensive in odor and very irritating to the skin. Despite a poor appetite, there had been no less of flesh but the strength had been considerably impaired.

Physical examination revealed a well built woman, rather stout; muscles flabby; skin sallow; lips and mucous membranes pale. Over the apex of the heart, was soft, blowing, systolic murmur, transmitted but a short distance into the axilla. This murmur was regarded as functional. The pulse was slow and of fair quality. There were no evidences of arteriosclerosis.

The abdomen was negative, except for slight tenderness in the left lower quadrant, elicited on deep palpation. On vaginal examination, I found a moderately relaxed outlet with a deep vagina, stained by a thin, bloody discharge. The cervix uteri was high, small and senile; the fundus small, freely movable and in anteposition. In the cul-de-sac, projecting slightly toward the left, was a club shaped mass, cystic to the feel, movable and slightly tender. It was about the size of a lemon. The right ovary was distinctly felt, was small, hard and non-sensitive. The left ovary could not be palpated.

The blood showed 55 per cent. of hemoglobin and the urine, except for a faint trace of albumin, was normal.

We had here, in the cystic tumor, bloody discharge and history of the pain and tenderness, taken in conjunction with the age of the patient and the absence of any probability of infection, as typical symptoms and signs of new growth of the tube, as can usually be obtained. As the ovary could not be felt, however, I made the diagnosis of neoplasm of the ovary, despite the bloody discharge, which is unusual in ovarian growths, occuring after the menopause. The operation, two days later, showed the mistake.

On opening the abdomen, a most unusual picture presented. I found a small uterus; normal, senile structures on the right side and a small atrophic ovary on the left. The left tube was sausage shape, about ten centimeters long, and half as wide, and its surface showed a curious, mottled appearance. Even the smallest vessels were clearly defined, so exquisite was the injection of the arteries. There were slight, spiderweb adhesions and after these were loosened, the tube was readily lifted out of the incision. The swelling was confined to the distal end of the tube, there being about three centimeters of the isthmus which were apparently normal.

The tube and ovary were easily tied off and removed and the incision closed. In order to make sure that the uterine mucosa was normal, a curettement was done.

The examination in the laboratory showed the growth to be a typical adeno-carcinoma. The essentials of the report are as follows:—The tube, fairly firm on pressure and apparently thick walled, is covered by many light

adhesions. It is 11 centimeters long; the distal end is bulbous and has a diameter of 5 centimeters. The ovary is small and atrophic.

Histologic sections, taken from the uterine end of the tube, show beginning hypertrophy of the epithelium and suggest a possibility of commencing carcinoma. The lumen is partially filled by an exduate of swollen cells and hypertrophied convolutions, which are apparently attempting to occlude the tube. In sections from the center of the tumor, the lumen is filled with a new growth, in places suggesting squamous cell carcinoma but in other places, showing the glandular arrangement, typical of the adenoid variety. The cells are stained irregularly and show active cell divisions, with many karyokinetic figures. The growth is exceedingly cellular and the blood vessels are poorly formed. The uterine curettings are normal.

On account of the thin tubal walls and the rich lymphatic supply, metastasis from carcinoma of the tube usually occurs early, so that the prognosis is always grave. This patient made an uneventful recovery and according to a letter received from her physician on March 20, 1905, she has remained perfectly well, there having been no signs of a recurrence of the tumor.

502 Washington Arcade.

Repair of a Vesico-Vaginal Fistula Through an Incision in the Anterio Bladder-Wall.

By WILLIAM F. METCALF, M. D.
Detroit.

Mrs. B.——, aged forty-four, on Feb. 20, 1902, consulted me for vesico-vaginal fistula. The history was that one year previously she had had the uterus and adnexæ removed per vaginam by another operator

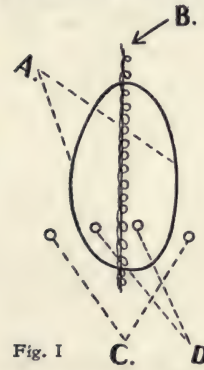

Fig. I

Plan of Suturing in Closing The Vesico-Vaginal Fistula.

A—Edges of fistula.

C—Ureters before operation.

D—Ureters after operation.

B—Suture closing fistula.

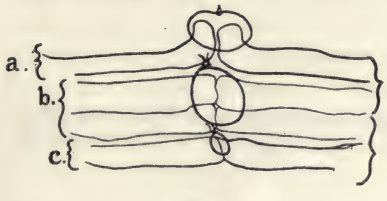

Fig. II.

(*b.*) Vesical and vaginal wall, *adherent* for a distance from the scar dissected out, were sutured en masse.

(*a.*) Vesical mucosa sutured with edges inverted toward the lumen of the bladder. The final suture in closing the fistula.

(*c.*) Vaginal mucous membrane, brought together by the first stitching, which in part was really combined with (*b.*)

and the vesico-vaginal fistula followed. During the succeeding year she had undergone five unsuccessful operations, by two different operators,

for its repair. I found that the posterior bladder-wall had been destroyed from one ureteral opening to the other.

On February 22nd, she was placed in the Trendelenburg position; incision was made above the pubis; the peritoneum was stripped upward to the fundus and the anterior wall of the bladder was opened by incision through its entire length. Catheters were then passed into both ureters; the cicatrical margins of the fistula were removed; and the edges of the vesical mucosa were raised from the underlying structures.

The edges of the vaginal mucous membrane and subjacent tissues were approximated by two layers of continuous button-hole sutures of catgut. The edges of the vesical mucosa were then inverted into the bladder cavity and approximated by a like suture.

The distal ends of the ureteral catheters were brought out through the urethra and the wound in the anterior bladder-wall closed. The incision in the abdominal wall was then closed without drainage.

The ureteral catheters were left in situ for two days, after which a self-retaining vesical catheter was used for five days. Meantime irrigation was performed twice daily.

The result was all that could be desired. I saw her the first of March, 1905, when she said she had had no bladder trouble since.

646 Woodward Avenue.

TRANSACTIONS OF SOCIETIES

WAYNE COUNTY MEDICAL SOCIETY.

May 1.

"Bile Tract Adhesions." Robert Tuttle Morris, Professor of Surgery, Post-Graduate School of Medicine, New York. Discussion: Theodore A. McGraw, Hal. C. Wyman.

May 8th.

Recipients of the Nobel Prize for Work in Medical Science:
Introductory: Edwin S. Sherrill.
Prof. Emil von Behring: Guy L. Kiefer.
Major Donald Ross: F. W. Mann.
Prof. Neil Finsen. H. R. Varney.
Prof. J. P. Pawlow: H. E. Safford.

May 22nd.

Appendicitis: When to Operate. S. E. Sanderson. Discussion: E. B. Smith, J. B. Kenndy.

May 29th.

The Classification of Insanity. C. W. Hitchcock. Discussion: J. A. Winter, Samuel Bell.

DETROIT ACADEMY OF MEDICINE.

April 25th.

"Instrumental Methods for the Study of Human Physiology and Their Relation to Experimental Medicine." W. P. Lombard, M. D., Professor of Physiology in the University of Michigan, Ann Arbor.

May 9th.

Inaugural Dissertation. **"The Radical Mastoid Operation."** Ray Connor, M. D.
"History of the Analysis and the Modification of Milk." Dr. Rammage, American Color Works, Detroit.

DETROIT MEDICAL JOURNAL

A MONTHLY EPITOME OF PRACTICE AND THERAPEUTICS

HERBERT M. RICH, M. D., Managing Editor

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Detroit's New Milk Ordinance.

On May first the new Milk Ordinance adopted last year by the Council, and the Dairy Rules of the Board of Health, became operative. No more essential work for the continued health and prosperity of Detroit has been undertaken for many years than this question of a milk supply, and it is to be hoped that public opinion will support the Board of Health in their endeavors to enforce the new ordinance.

The use of milk is the most wide spread of any article of diet in the world, not only the human race but all mammals substisting on it for a part of their lives. The guarding of the milk supply against dilution with water and gross adulteration has long been a matter of care on the part of public officials. More recently they have been obliged to adopt new precautions to prevent the introduction into milk of preservatives which, taken continually into the body, might be poisonous. But with the science of bacteriology has come a new and fuller knowledge concerning milk and its changes. Coincident with this occurred a remarkable growth of cities so that the process of furnishing every house in them with its food supply underwent great changes and became involved and complicated. So far as milk was concerned, the chief result was to increase very greatly the length of time elapsing between the actual milking and the delivery to the consumer. Whereas, in the country and small towns, one may have for breakfast milk drawn from the cow on the same morning, in the large cities this is impossible. One is fortunate indeed if his milk is not more than twenty-four hours old, and probably much of it in Detroit is thirty-six hours old before it even reaches the customers. Bacteriology has shown that in warm weather, this delay has a very remarkable and deleterious effect on the quality of the milk. One bacterium kept in milk above 60° F. may increase to 300 in two hours; to 10,000 in six hours, to 10,000,000 in nine hours, and to 2,000,000,000 in eighteen hours. The number of bacteria in unclean milk which has stood in a warm place for twenty-four hours, is actually almost beyond belief. Probably no single result of the science of bacteriology will have greater ultimate

effect in reducing mortality than its application to milk as a food, especially for infants.

Coarse dirt, hair, powdered cow-dung, etc., is often seen in milk, and can be easily detected. Such milk usually sours early. In connecting with what other article of food would the human race regard with equanimity the dusting with powdered cow-dung? But typhoid fever bacilli, the diphtheria germ, the infecting agents of scarlet fever and tuberculosis, are not so easily discovered. In fact, the milk may be macroscopically of the highest standard of excellence and yet be capable of doing great harm. That this is no fanciful danger was shown not long ago by the publication of a series of 330 epidemics definitely traced to the contamination of the milk supply.

Not all milk contains the pathogenic organisms mentioned, but practically all milk does contain organisms which, while not immediately pathogenic in themselves, do break down the organic constituents of milk and produce toxins of great virulence.

The three factors concerned in the number of bacteria in milk are (1) the cleanliness of the milk; (2) the temperature at which it is kept; and (3) the number of hours elapsing before it is consumed. The reason why precautions are more necessary than formerly concerning the milk supply of Detroit is, as before mentioned, because the last factor, that of time between the milking and the consumption, has been greatly increased by the growth of the city. The new milk ordinance, then, very properly insists on the observance by the dairyman of the first two factors. There is nothing unreasonable about this. Any article of food, particularly if fed to children, ought to be kept clean. This is an elementary first principle of correct living. The second factor, that of temperature, is at once the most essential and most difficult of the three. It means, in warm weather, ice continually in contact with the milk bottle from immediately after milking until the milk is consumed.

In New York, Rochester, Milwaukee, and Chicago dairymen have co-operated with the city authorities in an effort to produce the best results in the milk. The greatest force in the attainment of an improved milk supply, however, is public opinion. If customers insist in patronizing dairymen who are known to fulfil the proper conditions to produce the best milk possible, then these conditions will be fulfilled generally.

The question of greatest difficulty is that of transportation in the summer time. Ice is expensive and melts quickly, but any leniency in the enforcement of the rules at this point is fatal to the success of the plan. Chicago's ordinance gives the Board of Health the right to confiscate any milk offered for sale at a temperature exceeding 60° F. This calls for ice and plenty of it in hot weather. The Detroit ordinance is excellent; the only question now is the enforcement. It is to be hoped public opinion will support the Board of Health in every effort to improve the quality of our milk supply!

Mortality on the Isthmus.

Through the kindness of Col. F. J. Hecker, late member of the Isthmian Canal Commission, we present to our readers in this number an authoritative statement from Col. Gorgas, Chief Sanitary officer of the Isthmian Canal Commission, on matters of medical interest at the Isthmus. It is gratifying to learn that, notwithstanding the great disadvantages under which he and his medical assistants have worked, the mortality among the employes of the Canal is little greater than the general mortality of Detroit. That the sanitary conditions are not perfect is evident from the fact that the mortality is thus large with no deaths among infants which have so great an influence in increasing our death rate.

It may be said, also, that the real test of the efficiency of the sanitary corps is yet to come, but with the completion of the measures which we are told are under way, additional safeguards against the advent of pestilence will be provided.

The disastrous fiasco of the first French company on the Isthmus has misled many people into a misjudgment of what the French really did in Panama. From the latest book * on that subject, by a high authority, it seems that the second French company was really much better organized and managed than has so far been the case with the American project. Among other things, their mortality was just about the same as that on the Isthmus at present. However, as we said above, the real test has not yet come and it seems certain that nothing less than the extensive plans of Col. Gorgas, including the sanitary management of the cities of Panama and Colon, could be expected to succeed. In this respect, the present opportunity is much greater than that of the French and we look for greater results. With it all the medical profession is certainly proud to have a man of Colonel Gorgas' ability to direct this work.

The Typhoid Fever Commission.

The recent appearance from the Government press of two large volumes containing the complete report of the Committee to Investigate the Typhoid Fever Epidemic among the soldiers of the Spanish War, recalls to mind the untimely deaths of two of the three members of this commission. To Dr. V. C. Vaughn, of Ann Arbor, falls the melancholy duty of chronicling in the introduction, the death of his two associates, Major Walter Reed, and Major E. O. Shakespeare, before the publication of the work. Major Reed's death during his yellow fever investigations, is familiar to all, and Dr. Vaughn states that he believes Dr. Shakespeare's death to have been hastened by his exhaustive labor on the typhoid commission. The price of our increasing knowledge is high, when paid for by the lives of such men, and we are again reminded that scientific investigation of pestilence is fraught with personal danger not to be forgotten. It seems unfortunate that the world should lose such men as these two, just as the zenith of their career of usefulness.

*"Problems of the Panama Canal," by Gen. Henry L. Abbot.

EDITORIAL NOTES

Dr. J. K. Gailey has moved his office to the Washington Arcade.

Dr. George W. Moran now has offices on the lower floor of the Pasadena Building.

The Annual Meeting of the Huron County Medical Society was held at Sebewaing recently.

Dr. Hutchings, of Ann Arbor, is reported to be but little better. He is suffering from an attack of lock jaw.

Dr. Devendorff, of Woodward Ave., has given up his Detroit residence and removed to Birmingham, Michigan.

Dr. V. C. Vaughn, of Ann Arbor, was recently elected Vice-President of the American Society of Tropical Medicine.

Dr. Joseph Sill, the oldest physician of Kalamazoo, died April 23rd, aged 83 years, from an illness of twelve years, caused by a fall.

Dr. Charles Goodwin Jennings, of Jefferson Ave., attended the farewell dinner given to Dr. Osler in New York Tuesday evening, May 2nd.

The American Association of Pathologists and Bacteriologists held its fifth annual convention the last week of April at Chicago University.

Dr. Wm. A. Dunn, of Boston, has been appointed to the Medical Staff of the Vatican in Rome. This makes him consulting physician to the Pope.

Dr. P. M. Hickey was a delegate to the American Anti-Tuberculosis League, Atlanta, Ga., April 17-18, and read a paper on "Skiagraphy of the Tuberculous Chest."

Dr. Bigelow, house surgeon at Grace Hospital for the past two years, has severed his connection and will practice at Reading, Mich. Dr. George Kessler is his successor.

The Resignation of Dr. Burnham, medical attendant of the Trimountain mine, took effect on May 1st. He is succeeded by Dr. Howlett, Dr. Burnham's assistant for some time past.

On April 29th Gov. Warner appointed Dr. Walter E. Wilson, of Grand Ledge, as a member of the pardon board to succeed Dr. F. W. Shumway, now secretary of the state board of health.

Dr. and Mrs. C. D. Aaron gave a large reception to the physicians and attendants of the exercises of Clinic week at the Detroit College of Medicine, on the evening of Tuesday, May 2nd.

Dr. G. C. Chene and Dr. Geo. W. Robinson, this year graduates of the Detroit College of Medicine, have taken up their duties, having been recently appointed to the house staff at St. Mary's Hospital.

Internes for the University Hospital, Ann Arbor, have been chosen for next year from the senior medical class as follows: R. F. Brookhart, D. H. Eaton, E. J. Thomas, R. A. Brown, W. A. Chase and Carl Miller.

City Physician John W. Hoffman was nearly asphyxiated at his home, 315 Jefferson Ave. during the night of April 26th, and his condition for some time considered serious. It is now thought that he will fully recover.

Dr. Wm. L. Dickinson, of Bay View, read a paper at Pittsburg before the American Proctological Society on May 6th, on "Personal Experience in Employment of Mechanical Vibration in the Treatment of Rectal Diseases."

The ordinance appropriating $100,000 for the building of a contagious disease hospital for the city of Detroit, has finally passed the Council, and the work has already been begun on the plans for the hospital. Its location has not as yet been announced.

Dr. Griffith Thomas, police surgeon of the Woodbridge St. station, was viciously attacked by Leo Tucker, a prisoner, while he was answering his call, and given a blow which knocked out several teeth and in a clinch the little finger of his right hand was bitten almost off.

Dr. Pierre Roux, the famous cancer specialist and director of the Pasteur Institute, has been secured by John D. Rockefeller to come to this country to treat Dr. Wm. R. Harper, president of the Chicago University. Dr. Roux has a serum for cancer which has been used many times with success.

A New Plan for the treatment of Meningitis has been advanced by Dr. Ludvig Hektoen, of Chicago University. This consists in the withdrawal of a portion of the cerebro-spinal fluid, replacing it with pure serum which he believes will assist the white corpuscles in combating the toxic products.

Dr. E. K. Herdman was re-elected city physician of Ann Arbor by a vote of 9 to 6. The aldermen spoke highly of Dr. Herdman's record, and President Gilmore, superintendent of the University hospital, said that Dr. Herdman had got more from the hospital than any other city physician Ann Arbor has ever had.

An Association to Give Instructions in every community in First Aid to the Injured is being organized at Washington, D. C., called the National First Aid Association of America, with Miss Clara Barton, Julian B. Bubbell, of Washington, and Mrs. Sewall Reed and Harry H. Hartung, of Boston, as directors. Gen. Miles is among the charter members.

The Bizbee, Ariz., Daily Review gives a very complimentary reference to Dr. J. C. Diver, formerly of Kalamazoo, where he practiced medicine for three years. Dr. Diver was forced by the rigorous climate of Michigan to seek a milder and more sunny clime. After a combined health and pleasure trip, he finally decided on taking advantage of the possibilities of Bisbee.

For Sale:—A fine twelve room brick house and office in a good southern Michigan town. House heated by a furnace, rooms convenient, large, well lighted. Cement walks, curbing. Nice shade. Verandah. Hard and soft water. Everything complete. Good large barn. Small garden and fruit.

Practice from $2,500.00 to $3,000.00 annually. Collections good. Introduction. Terms and particulars on application to Mrs. G. W. Ferris, 70 Englewood Ave., Detroit.

Harper Hospital is left $10,000 by the will of Delia A. Hanmer, who died at her home, 53 Alexandrine Ave. West, April 27th. The bequest is to be used for the endowment of a room to be known as "The Hanmer School of Music Room," and as is stated in the will, is to be used for patients that are not chronic but those for whom there is reasonable hope of benefit, preference to be given to those who have been musicians or instructors in music. Patients are not to be retained more than four weeks, if others are waiting.

Dr. Wilfred Grinfell, the Oxford University medical missionary, who is also Magistrate and master seaman on the shores of Labrador, and who is generally remarked as the original of Norman Duncan's "Dr. Luke, of Labrador," spoke in Detroit recently of his work in the land of the wilds. He is a pleasant-looking Englishman and speaks with a slight accent and modestly of his share of the work done for the fisherman of Labrador. The object of his trip through Canada was to get assistance for a much needed hospital on the Quebec coast of Labrador.

At the Eighth Annual Meeting of the American Gastro-Enterological Association, held at the Academy of Medicine, New York City, on April 24 and 25, 1905, the following officers were elected for the ensuing year. President, Dr. H. W. Bettmann, of Cincinnati; 1st Vice-President, Dr. S. W. Lambert, of New York City; 2nd Vice-President, Dr. John P. Sawyer, of Cleveland; Secretary and Treasurer, Dr. Charles D. Aaron, of Detroit. Councillors, Dr. William G. Morgan, of Washington; Dr. A. L. Benedict, of Buffalo, and Dr. J. Kaufmann, of New York.

On April 1st, Dr. O. P. Barber's home, one of the handsomest in Saginaw, was entirely destroyed by fire and the doctor narrowly escaped death. The flames were discovered by a passerby and Dr. Barber was awakened. Quickly realizing his danger, he tied a sheet to the bed and attempted to lower himself from the window. When half way down, the sheet broke, and the doctor fell, badly spraining his ankle and breaking several fingers. Mrs. Barber and the son were away at the time. The loss will be about $20,000 as nothing was saved but a diploma and some instruments.

Chicago's Advance in Publice Health has been so great that there has been a gain of twenty years in the average lives of Chicagoans in less than a quarter of a century. This is due largely to the prevention of child mortality by giving better milk, water, drainage and ice. Chicago's health department stands in the front rank in general preventive medicine and sanitary science. It was one of the first to moderate diphtheria ravages by antitoxin treatment. In 1873 the per cent of deaths of children less than one year old was thirty-seven, and this year it was nineteen per cent.

Dr. J. Newton Babcock, of Bay City, was sentenced to the State Reformatory at Ionia for not less than one year nor more than five years for forging the name of George Drake to a check for $3.65. The case has excited more than ordinary interest, as Dr. Babcock has been for several years a victim of the drug habit. Efforts to cure him have proved unavailing and he finally became entangled with the law. While he had asked for an opportunity to better his condition, after a consultation with some of the friends of the prisoner, the Judge decided to place him under restraint, in the hope of thoroughly curing him of his love for drugs.

Alumni Clinic Week.

The program for the Clinic week of the Alumni Association of the Detroit College of Medicine was carried out in detail and furnished an entertainment which will long be remembered. The registration books showed an attendance of over 300. The social features were well attended and were much enjoyed. The reception given by Dr. and Mrs. Chas. D. Aaron, was the social event of the week, and their beautiful home was taxed to accommodate the visiting doctors and their wives. Monday afternoon a special car conveyed the Alumni to Eloise where two interesting clinics were held. Dr. E. L. Shurly lectured on the tent treatment of tuberculosis, illustrating his remarks with patients who were taking that treatment. Dr. Marker, of Eloise, presented a number of selected cases of paresis and dementia, illustrating various types of these diseases; the clinical manifestations were discussed in an able manner by Dr. Inglis.

Dr. C. W. Barrett, of the class of '95, Professor of Gynecology in Chicago Clinical School, presented an interesting clinic at St. Mary's Hospital. Dr. Barrett is a brilliant operator and is possessed also of the happy faculty of accompanying each procedure with explanations given in a lucid and convincing way. His demonstration of operations on the round ligaments was a finished piece of surgical technique.

Dr. Haughey, of Battle Creek, class of '88, gave an interesting talk on Variola, illustrated by patients who had been discharged from the city hospital. The doctor dwelt on the difficulties of diagnosis and the essential points to be considered as found in the recent outbreak of cases in Battle Creek.

Space will not permit us to mention the many other interesting papers and clinics which contributed to the entertainment of the Alumni.

The annual business meeting resulted in the election as President, Dr. H. W. Yates; Vice-President, Dr. C. W. Barrett; Secretary, Dr. G. J. Anderson.

The Walker-Gordon Dairy.

On April 26 a party of physicians and prominent men, including the City Board of Health and representatives of the press, visited the Walker-Gordon dairy near Rochester, as the guests of the company. This dairy is on a farm owned and managed by Mr. J. C. Day, of Detroit. It is ideally located and the buildings have all been newly constructed in accordance with the latest ideas in dairying. The care of the cows and the handing of the milk are carried out according to the methods perfected by experiment and practice in the hands of the Walker-Gordon Company in Boston and New York.

The food, drink, exercise and toilet of the cattle, as well as the breeding and points of the individual cow, are all the result of careful experiment and observation. The cattle are examined regularly for disease by a veterinary surgeon. The milking is done with great care. No hay or dusty substance is kept in the stable and the stalls are regularly and thoroughly cleaned and flushed by plenty of water. Immediately after milking, the milk is cooled to about 50 degrees F. and is bottled in sterilized quart bottles and packed in ice for shipment.

The result is first, clean milk, kept cool until delivered. Two other important considerations are that it is free from suspicion of bearing disease and it offers an almost absolutely constant ratio of its constituent elements.

The establishment and successful operation of this company in Detroit is a matter of great interest and value to every physician, in and near the city.

It is important to know exactly the function of the milk laboratory as a considerable degree of misapprehension in regard to it exists in the popular mind. The milk produced under the conditions mentioned above is sold in the open market in quart bottles. It has no particular connection with the laboratory. It is important for physicians because it is a pure milk with a very low bacterial count.

This is valuable in feeding typhoid cases and any bowel cases. It is the best for using in the home modification of milk for infants for two reasons: 1) The small number of bacteria; (2) the constant fat percentage. In hot weather it is particularly important that such milk as this be used for infants.

The milk laboratory is in effect, a pharmacy, for the making of properly modified milk for babies. The Walker-Gordon milk is here modified according to physicians' prescriptions by experts and is delivered to the patient, each feeding in a separate bottle. The laboratory does not prescribe. If laboratory milk does not agree with a child, the fault lies in the physician's prescription and not with the laboratory.

Any change wished by the attending physician, such as the addition of cereals, heating, lime water, etc., will be carried out by the laboratory. The plant in Detroit is in entirely competent hands and we are sure that the physicians of Detroit will welcome this useful institution and guarantee it a permanent place in the city.

RECENT DEATHS.

Dr. G. E. Mooney, aged 35, a bright young physician residing at Whitemore, Mich., died suddenly April 21st.

Dr. Patrick H. Reaney, son of Capt. Henry Reaney, of the lighthouse service, died at his residence, 41 Burlingame Ave., of pleural pneumonia. He was born and educated in Detroit, being a graduate of the Michigan College of Medicine, and for a time was connected with St. Mary's Hospital, Detroit.

Dr. Wm. M. Edwards, Medical Superintendent of the Michigan Asylum for the Insane at Kalamazoo, died recently of heart disease at the University Hospital at Ann Arbor. The profession will recall his work in connection with the colony system of caring for the chronic insane. To him is due the establishment of a detached hospital for the care of acute cases, the first of the kind in Michigan. Dr. Edwards was born near Peru, Indiana, attended the state schools and graduated from the medical department of the University of Michigan in 1884. Among the many appointments held by the doctor has been those of assistant physician and superintendent of the Kalamazoo Asylum for the Insane, and non-resident lecturer to the medical department of the University of Michigan. For a young man, Dr. Edwards had attained high rank as a specialist, and his death is a great loss to the entire medical fraternity.

PROGRESS OF MEDICAL SCIENCE

Sterilization of Cutting Instruments.

Of fifty-one prominent surgeons who were asked their practice in the sterilizaton of knives and scissors by H. A. Royster (Ann. Gyn. and Ped., Feb. '05), twenty boil them, two use dry heat, and twenty-one use chemical agents, chiefly carbolic acid, alcohol, or both. Many complaints are made of the ruining of cutting instruments by the process of sterilization. The author has made experiments to determine the effects of the various methods and arrives at the following conclusions:

1. Knives can be safely sterilized by chemical and mechanical means without the use of heat in any form.

2. The majority of American surgeons are using carbolic acid, or alcohol, or both.

3. Immersion in 95 per cent alcohol has the least, and boiling the most effect in dulling the edge of a knife.

Defects of the Agglutination Test.

Oskar Klotz, Montreal (Journal A. M. A., March—), calls attention to certain possible sources of error, aside from the necessity of a more uniform technique rendering possible comparisons of work by different observers. The age of the culture affects the result as its susceptibility to agglutinins, increases for the first six months after isolation from the animal body and growth on artificial media. Inoculations in animals with broth culture produces in their sera, beside the agglutinins, precipitins whose reaction in broth culture can not be distinguished from true agglutination, the organisms being deposited mechanically in the precipitate. Pseudo-clumping may be obtained by using emulsions of bacteria in undiluted

broth and testing against the above serum. The agglutination of a micro-organism varies with the medium in which it is grown, the reaction of that medium, the temperature of the incubation, and the number of organisms present in the emulsion. Pseudo-clumping may be due to sudden changes of temperature or to the addition of certain chemicals. Carbolic acid or chloroform added as preservatives to immune serum does not affect the agglutination reaction. In using the dried blood test, paper having a soluble gloss should be avoided for collecting the blood. Klotz finds the macroscopic method for determining agglutination the most useful and rapid, and places a time limit of three hours on all these reactions.

Ficker's Diagnostikum for Typhoid Fever.

In the Muenchener Medizinische Wochenschrift of Jan. 17, 1905, are three articles relative to the use of the "Diagnostikum" of Ficker, whose original paper appeared in 1903. Selter at Bonn conducted parallel tests upon 24 undoubted typhoid patients, using both the "Diagnostikum" and the Widal reaction under similar conditions. Every case gave positive Widal, but 6 failed to react with the "Diagnostikum." He concludes further that the latter test does not succeed so early in the disease as the former, and it also disappears sooner; that there is doubt whether in the long run it will prove easier and cheaper than sending to the nearest laboratory for a Widal test; and that paratyphoid will be overlooked. Acknowledging the value of Ficker's test under certain circumstances, he yet predicts that it will never replace the Widal.

Flatau and Wilke, at Kiel, carried out similar tests, in a series first, of known typhoid cases; second, of other diseases; third, of patients who at some time previous had been sufferers from typhoid. Their results credit the "Diagnostikum" with an accuracy nearly, if not quite, equal to the Widal. They recommend it unreservedly to the general practitioner and predict that it will replace the older test.

Eichler, of Munich, made tests with the "Diagnostikum" in tropical climates, and after several months, even though not kept in cool places, it gave positive results. He believes it of inestimable value to men unable to avail themselves of the Widal reaction, such as army and navy surgeons, ship physicians, etc.

(The "Diagnostikum' " is a fluid emulsion derived from typhoid cultures, sterile, and microscopically free from the bacilli. To a given quantity of this emulsion is added a certain quantity of serum from the patient suspected to have typhoid. It is necessary to draw 5 or 6 c. c. of blood from the patient. A positive reaction consists in the formation of a light flocculent precipitate, visible macroscopically after from 5 to 20 hours.)—C. S. OAKMAN, M. D.

Stone in the Kidney.

Wright (Clinical Review, March, 1905), summarizes a very readable paper upon this topic as follows:

First—Kidney stone may occur at any time of life from earliest infancy to ripe old age. They are the most frequent and give rise to the greatest amount of suffering of any form of surgical disease of the kidneys.

Second—Quiescent calculi are as dangerous to the patient as unsuspected stone and ought to be removed.

Third—The more complete the obstruction of the ureter the more rapidly the renal destruction takes place.

Fourth—The clinical manifestations of kidney stone do not depend upon its size. A small stone just large enough to prevent its escape and composed of oxalate of lime will cause more suffering and damage to the kidney parenchyma than a very much larger deposit of softer formation, as well as completely disable the patient while the destructive changes are taking place, although clinical symptoms are not intensely active.

Fifth—While generally unilateral it occasionally occurs in both kidneys. At times the reflex symptoms point most prominently to the sound kidney; the stone being found not infrequently in the side free from pain.

Sixth—The diagnosis is not difficult in typical cases, but owing to the stone remaining quiescent an indefinite length of time, in some make an early recognition almost impossible.

Seventh—Owing to the fact that the kidney stone will put on the livery of infectious diseases positive diagnosis is difficult if not impossible in those cases where the classical symptoms are absent.

Eighth—There are few diseases of the kidneys more certainly fatal when left alone, or more successfully treated when met with proper interference, arresting the destructive changes taking place in the kidney and restoring the viscus to its physiological function.—F. B. TIBBALS, M. D.

Urine Examination.

R. C. Cabot, Boston (Journal A. M. A., March 18-25), states that incited by a statement of Councilman that the chemical and microscopic examination of the urine failed to give certain information of the character of the renal lesions, as well as by discrepancies coming under his own observation, he has compared critically the records and postmortem findings in the cases that have come to autopsy in the Massachusetts General Hospital since 1893. Although the number of cases is not large, he thinks they warrant the following conclusions: 1. Many cases of acute glomerular nephritis occur that are unrecognized by any known methods of examination. 2. The diagnosis is at fault in some cases of subacute and chronic glomerular nephritis, but in the great majority of cases the condition of the urine, taken in connection with other symptoms, foretold the autopsy findings. 3. In chronic interstitial nephritis the diagnostic resources appear to be neither so sufficient as in the chronic glomerular form, nor so inadequate as in the acute glomerular nephritis. In about a third of the cases the diagnosis was correctly made before death. 4. Among other conditions mistaken for nephritis by too much reliance on the urinary findings are senile and arteriosclerotic condition, mistaken for chronic nephritis, while in conditions involving passive congestion or acute kidney degenerations, the urine occasionally simulates that of acute nephritis. Even where no lesions are found at autopsy the urine is sometimes highly albuminous and full of casts. 5. In ordinary urinary examinations the common errors are: (a) The attempts to estimate urea without accurate knowledge of the patient's metabolism. (b) Stating that renal cells are present when all that is seen are small mononuclear cells, perhaps from the kidney tubules, perhaps not. 6. Cryoscopy and other attempts to test the renal permeability more directly are not yet capable of supplementing in clinical work the older methods of examination. Cabot holds that the vast majority of estimations of urinary solids, including urea, are a waste of time, since they are not and can not be made part of a general metabolism experiment, and that the attempt to estimate the anatomic condition of the kidney by measuring albumin and by searching for casts is fallacious. The most reliable data are the twenty-four-hour quantity, the specific gravity and the color.

Blood Pressure in Disease.

The Riva-Rocci-Cook sphygmomanometer has been found the most accurate recorder of blood pressure, especially when the wide cuff is used (12cm.) Slight inaccuracies, however, are still unavoidable, and variations are to be expected under unusual conditions of muscularity, posture, exertion, mental excitement, state of blood vessels, etc. Investigators are now tolerably well agreed that average normal blood pressure is between 100 and 130 m. m. of mercury. In the observations of Robert S. Morris and Charles W. Edmunds, of Ann Arbor (Med. News, Jan. 14, '05), great pains were taken to exclude all errors. They conclude that in renal disease "it may be said that an acute inflammation or degeneration may or may not raise the pressure, but that a chronic interstitial nephritis practically without exception causes an increase, which, if it terminates in uremia, may give still higher readings. As the uremic symptoms disappear, the pressure becomes lower." * * * Chronic parenchymatous nephritis appears not to exhibit this phenomenon. In cardiac lesions they confirm the previous experiments, which have given irreconcilable anomalies. No constancy was discoverable in the variations of blood pressure in different forms of valvular disease, and indeed, normal readings were very often the rule. Therefore, generalizations are impossible. It is suggested that observations on the diastolic pressure might be of value in this connection, as nearly all experiments heretofore have concerned the systolic pressure. In exophthalmic goitre it was found that the arterial tension was increased in all cases. Explanations are not satisfactory, but it seems probable that vasomotor action is responsible. In anemia, on the other hand, the tension is as regularly decreased. In typhoid fever, likewise, tension is lowered, progressively with the advance of the disease; but coincident with perforation Crile reported sudden rise. If this is verified, it will be a valuable aid to diagnosis of

perforation. The agency of arterial sclerosis in blood pressure is probably overrated, and is now evident that it plays a distinctly minor role. The inhalation of amyl nitrite is shown to produce a great initial fall of pressure within one minute, followed at once by a rise somewhat above the original point.

It is urged that a wider interest in this new field be displayed by actual experimentation in all hospitals, as its value, while not yet fully known, is yet important beyond a doubt.

Injuries to the Eye From Particles of a Copying Pencil Getting Into the Conjunctival Sac.

Morrison (Ophthalmic Record, Jan., '05), reports two cases.

Case 1. Patient girl aet. 15. While sharpening an indelible lead pencil a particle of the point got into the right eye. Some pain and lacrymation followed which soon subsided, larcimation persisting, the tears being colored blue. Following morning eyelids were much swollen and discolored, sight blurred. Discoloration extended down the cheek.

Upon examination the conjunctiva was found swollen and deeply stained. A small piece of lead was removed from the lower cul de sac. Upper lid so thickened as to prevent inspection of the upper cul de sac. Cornea steamy and iris blurred. V= counting fingers. Eye was irrigated and atropia instilled and applications of boracic acid ointment used.

One week later patient presented herself again with the condition much exaggerated, area of scleral and corneal erosion corresponding to inner third of upper lid. The lid was everted and a gritty particle removed from the upper cul de sac. Cornea ulcerated.

The vision then began to improve and a symblepharon developed.

Improvement continued for about six months when a pterygium developed over the site of the corneal erosion. This was transplanted successfully, the only evidences of the trouble remaining were an area of corneal haze at the side of the pterygium and a slight ptosis from the cicatrization in the cul de sac. V= 20-15 ccm. + 1.25 Ds. Surface of cornea irregular.

Case 2. Patient, a foreman in manufacturing establishment. While sharpening an indelible pencil a particle of the point struck him in the left eye. Pain not great but the tears were stained blue. Four hours later pain became severe. Lids edematous and a foreign body was found in the cornea the epithelium of which was deeply stained. Vision blurred (6-200).

Foreign body was removed under holocain anæsthesia and atropia instilled. Hydrogen peroxide was used in the hope that it would act as a decolorizer. The following day the discoloration had largely disappeared. Small area around where the lead had been, persisting. One month after first presentation there was still a slight stain V= 20-30.

The coloring matter in indelible lead is usually methylene blue or methyl violet, which Graplin has shown produce a violent reaction when placed in the conjunctival cul de sac.—DON M. CAMPBELL, M. D.

Bilateral Hysterical Amaurosis.

By Adolph D. Pfingst, M. D., Louisville, Ky., (Ophthalmic Record, Feb., 1903).

A minister's wife, aged 42, of a neurotic temperament, gave the history of having had frequent attacks of pain along the spine for several weeks. After each attack her vision for close objects was dim, and at times it was impossible for her to read for several days following an attack. The patient was led into my office, apparently blind, Feb. 20. On the preceding day she had had a more severe attack of pain in her back than usual. Her vision at the time was, as far as she knew, as good as ever, but upon retiring at night her entire surroundings appeared green to her. Upon arising on the following morning she could not see, or, as she expressed it, "everything appeared black." It seemed to her as though a large, round, black disc covered each eye and that a faint light could be seen around the edges of the dark fields. The discs increased rapidly in size, and by noon the patient was in almost complete darkness. She still complained of some pain in the occiput and back, of a burning sensation in the vertex and an occasional darting pain in the eyes. Her family physician saw her at 11 o'clock and had me see her in the afternoon. At the time she was able to distinguish darkness from light, although she could not determine the direction from which the light was thrown into the eyes. Both pupils were narrow, but contracted more when exposed to concentrated light. Movements outward were limited in both

eyes, the eyeball being rotated outward but little beyond the middle line with great effort. The interior of both eyes, examined under a mydriatic, was normal. The patient, at this time, was extremely sensitive to the slightest pressure over the entire length of the spine and would cry out with pain when the spinous processes were touched. Examined in the dark room, the patient was unable to tell darkness from light, when the hand was passed between her and the light of an Argand burner.

A month later I was called again to see the patient and found her in the same condition as upon my first visit. The areas of hyperesthesia, however, were more numerous and extensive. The skin over the entire abdomen was so sensitive that mere contact with the hand would case her to cry out with pain. The spine was again extremely sensitive, especially over the spinous processes. Near the posterior superior spine of the ilium on the left side a hyperesthetic, congested area about three inches in diameter could be mapped out. Recovery from this attack was sudden, as in the previous one. Various means, entirely suggestive, were employed in the hope of cutting short the attack,, but blindness continued for ten days and then, as in the other attack, the vision returned to normal in several days. Physical examination of this patient and the examination of the urine made at different times revealed nothing noteworthy.

The diagnosis in this case can hardly be doubted. Its hysterical nature is indicated by the suddenness of the onset of the blindness, the retention of the pupillary reaction to light, the absence of pathologic lesions and its rapid and complete recovery with restoration of perfect function. The diagnosis is substantiated by the hysterical backache, the hyperesthesia over the spine and abdomen and by the paresis of the ciliary muscle and the contracture of the internal recti.—D. M. CAMPBELL. M. D.

Operation for Neuralgia.

In the Medical and Surgical Report of St. Luke's Hospital, Chicago, 1904, Dr. A. E. Halsted writes upon the "Extirpation of the Gasserian Ganglion as a Means of Treatment of Facial Neuralgia with a Report of Seven Cases." Medical treatment is of slight value, except in the mild forms, and the lesser surgical operations, like neurotomy, stretching, avulsion, neurectomy, injection of osmic acid,—while they give the patients relief, yet it is temporary. Certain pathologists have found indication that the disease has origin in the ganglion itself, though others claim it is purely peripheral. Whatever its seat, the permanent cure of long-standing, genuine, cases of this "the most terrible disease that afflicts mankind," has been accomplished only by the operation in question. It is, however, such a serious procedure that it should not be attempted until other means have failed. The pain has been known to cease spontaneously.

Mortality has varied in the different series reported, from 11 per cent to 33 per cent. Of the writer's cases, varying in age from fifty to seventy-one, one died on the fifth day, of uremia; one died of suppurative meningitis the sixth day; one died the thirteenth day of lepto-meningitis starting from a suppurating sphenoidal sinus. The other four recovered, although one had slight recurrence in the infraorbital region.

On his first three cases the author used the Hartley-Krause method, with a large osteoplastic bone flap. In the remaining four he followed the Cushing modification of the same, by which an opening is made and enlarged ad libitum with rongeurs, leaving a permanent deficiency in the skull.

The operation presents many difficulties. The cranium is hard to pierce and the instruments used are numerous,—but probably the most rapid method is by using the small trephine, followed by the DeVilbiss forceps for bone flap, or by the rongeurs if no flap is desired. The dura is sometimes very adherent and may be torn, thus exposing the brain to trauma and sepsis. Hemorrhage is the greatest obstacle for the speed and thoroughness of the operation, and this occurs chiefly from the middle meningeal artery; if wounded it must be tied or packed; occasionally the foramen spinosum can be plugged; in a few instances the bleeding is so stubborn as to necessitate packing and finishing the operation at a subsequent sitting. The cavernous sinus has been torn, but is controlled by gauze. The emissary veins may prove troublesome in the same way. The writer has found it advantageous to pack the wound for a few moments with a 2 per cent solution of gelatin to stop the oozing from small vessels. Compression of the cerebrum must be guarded against by careful retraction with special instrumnts. Undue carelessness has resulted, in aphasia, dyspnea, and general pressure symptoms Sepsis has always to be minimized by scrupulous asepsis.

The operation, although generally curative of the neuralgia, gives more or less anaesthesia of the side thus deprived of its sensory supply, while the sensation of heat and cold is frequently perverted. But the area thus affected diminishes markedly. The muscles of mastication are usually paralyzed, but this is unimportant, as the muscles of the opposite side are sufficient. Ankylosis of the temporo-maxillary articulation has occurred in a few cases, tending, however, to improve. There is corneal and conjunctival anaesthesia, which may lead to ulceration; panopthalmitis has been reported. To minimize these dangers, the eye should be protected during operation and have frequent irrigations afterward. Paralysis of ocular muscles and ptosis have happened several times from injury to the third, fourth, and sixth nerves, but have been transient. There may be complete or partial deafness on the affected side following operation, and suppurative otitis media is not unknown.

Relapses in cases of complete extermination of the Gasserian ganglion are very rare, and even in the instances recorded, the pain has been less in degree than previous to operation. The paper gives full bibliography.—C. S. Oakman.

Ultimate Results of Bloodless Hip Operation.

A. Hoffa, (Berlin Am. Jour. Orthopedic Surg., Vol. II, No. 3).

Hoffa's experience has led him to attempt bloodless reduction in cases only up to eight or ten years in unilateral dislocations, and six or eight years in bilateral dislocations A pronounced upward displacement of the femoral head on the dorsum of the ilium, with impossibility of pulling it down, at whatever age, requires such violence in bloodless treatment that the patient is exposed to extensive injuries, such as rupture of the vula, tearing of the perineum, fracture of the femoral neck or shaft, paralysis of the quadriceps, or even rupture of the vessels. The author has therefore abandoned bloodless treatment in high, stable dislocations. In young children, with loose hips, reduction is easy. In cases of greater permanent shortening and greater rigidity, the author never forces reposition, but repeats the manipulative operation once or twice, at intervals of a week or more, holding the position gained by each procedure by a plaster cast. "All forcible manipulations are to be avoided because no benefit is to be derived from such treatment and often very great damage is done even if the dislocation be successfully reduced." If, after three trials, the bloodless method fails, the author abandons this method of treatment, and often attains success by the open operation.

Following these principles, Hoffa has treated more than 400 cases, and reports the following results of the bloodless method:

Of 250 unilateral cases, at least one year after close of treatment,

Anatomic restoration with perfect function	30%
Anterior transposition with improvement	44%
Anterior transposition without improvement	20%
Reluxation	6%

Of 65 bilateral cases, at least one year after close of treatment,

Anatomic restoration with perfect function	8%
Anterior transportation with improvement	50%
Reluxation on one side	15%
Reluxation on both sides	27%

Early diagnosis aided by radiography is urged in the interest of early bloodless operation, for early treatment is as easy and as successful as the modern treatment of club-foot, which is now treated very early. In old and unsuitable cases, one of the palliative operations is advised, as resection of the head, or subtrochanteric osteotomy.

Of 100 cases, Narath (Arch. f. Orthopaedie, Band II, Heft 3), gives the following figures:

Anatomic restoration with perfect or very good function	59%
Good function	36%
Medium results	3%
Bad results	2%

* * * * * * * * * * * *

Of 24 hips operated by bloodless method before the advent of Lorenz in 1902, Ridlon (Chicago Jour. Am. Med. Ass'n., April 16, 1904), had the following results:

Perfect reposition	8%

Apparent reposition (Author believes these cases are usually classed as "perfect" reposition) 37%
Transportations 13%
Reluxation 21%
Failures 21%

* * * * * * * * * * * * *

Of 26 hips operated on in this country by Lorenz, studied by Ridlon (Jour. Am. Med. Ass'n., April 23, 1904), the latest reports are as follows:

Perfect reposition 8%
Apparent reposition 4%
Transposition 61%
Failures 27%

* * * * * * * * * * * * *

Accidents. torn perineum, paralysis, fracture neck of femur, fracture shaft of femur,—each, one case.

Of 26 hips operated by bloodless method by Ridlon, since the departure of Lorenz, in which the end results are known, (Ibid.)

Perfect reposition 23%
Apparent reposition 16%
Transposition 42%
Failures 19%

Accidents: fracture of neck of femur in two girls of nine and ten years.

—WILLIAM E. BLODGETT, M. D.

NEW INSTRUMENTS AND DEVICES

Mention of new instruments and devices in this department is entirely complimentary and articles illustrated are judged on their merits.

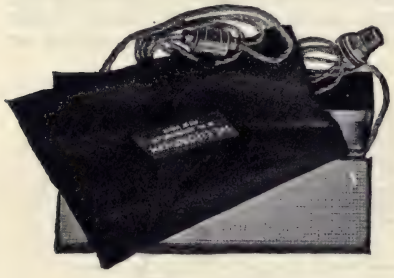
We invite manufacturers and physicians to send us matter suitable for publication under this head. A description of the device and an electrotype or half-tone with a base not greater than two and five-eighths inches should be sent.

Always mention the price of the article in question.

The management cannot undertake to return cuts unless postage for same accompany the letter with which they are sent.

To Our Readers—The Detroit Medical Journal publishes descriptions of such aids to the profession as it knows to be reliable and trustworthy. We shall be pleased to furnish information as to the articles mentioned, or the articles themselves, upon receipt of an inquiry.

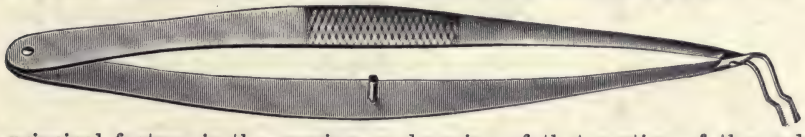
The Electrotherm.



This device is a substitute for the hot water bag. It is composed of wires insulated and protected by asbestos, woven into a light and flexible sheet or pad, which, when connected to the ordinary incandescent lamp socket, offers sufficient resistance to produce a constant and uniform degree of heat. If a poultice effect is desired, the pad can be used over one or two layers of damp flannel. It is light and flexible, warms up gradually, can be made to stay at a given temperature exactly for any length of time and requires no attention. Price, $6.50.

New Capsule Forceps.

Dr. Eugene Smith, of Detroit, has designed the instrument here illustrated.



The principal feature is the curving or dropping of that portion of the ends of the blade which contains the teeth, below the plane of the blades, that the teeth may set down into the pupillary space without tilting the forceps, the forceps being introduced closed, as for iridectomy. The end of the forceps is pushed forward till the curved portion, containing the teeth, is in the pupillary border, and

by gentle pressure against the lens, the capsule is seized and more or less forcibly within reason, by a little sudden twitch, extracted. The curve where the teeth are dropped is 1mm. in depth, and the part containing the teeth is 2mm. long. The blades open automatically 5mm., and when closed, except that portion containing the teeth, are 1½mm. apart. Price, 75c.

Travelers' Thermometer.

This cut is the exact size of a convenient thermometer to be carried in the pocket for the purpose of testing the temperature of rooms, cars, halls, etc. There

are many situations in which such an instrument might be useful. While intended primarily for doctors and nurses, it will be of service to the traveling public in general.

Ether and Chloroform Dropper.

Dr. O. C. Pedersen, of New York, in the January Annals of Surgery, describes this new device for the use of anesthetizers. It consists of a flanged stopper, by which the flow of the fluid can be regulated. The size and rate of the drops are fixed by adjusting the disk. These details require a few seconds of time. When the adjustment is made, the bottle will drop by the hour without interruption or

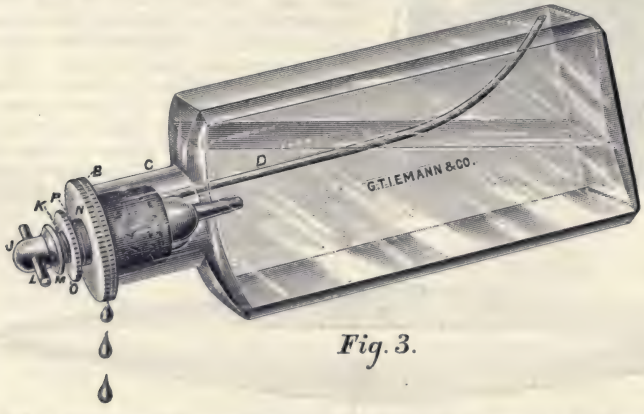


Fig. 3.

variation. At any moment it may be made to pour by turning it over so that the air-vent is submerged, or by turning the plug so that the channel is full-size, that is to say, so that the plug-groove and socket-groove completely correspond. The author has given the dropper the test of a full year's use in many cases of all kinds. In his hands it has never failed to work perfectly.

BOOK REVIEWS

International Clinics. Vol. I. Fifteenth Series. March, 1905. Edited by A. O. J. Kelly and others. Uniform with previous volumes. Illustrated. Philadelphia: J. B. Lippincott Co.

This new volume of a now well established quarterly contains as usual a number of very important and readable articles chronicling medical progress. The truly international quality of the publication is shown by the fact that this number contains articles by prominent clinicians in London, Paris, New York, Baltimore, Glasgow, Rome, and Philadelphia. There are from one to five articles under each of the following general heads: Treatment, Medicine, Surgery, Neurology and Obstetrics. In addition three authors contribute to the progress of medicine during 1904.

Among the more interesting articles may be mentioned the following, the first being particularly practical and suggestive: The Eye and Hand in the Diagnosis of Heart Disease; Early Diagnosis of Heart Disease in Children; Intestinal Adhesions; Carbohydrates of Human Urine; Treatment of Cardiac Asthma; The Starvation of Malignant Growths; Treatment of Glenard's Disease.

In the chapters on Progress we find no mention of the new agglutin test for typhoid, which promises to be of much use to the general practitioner. The following introductory sentences to Bloodgood's chapter on surgery are interesting: "Surgical technic is in advance of surgical diagnosis, and recent communications indicate a desire to improve the early recognition of surgical lesions. Malignant epithelial tumors are local lesions in their outset and can be cured by complete excision. The public must be educated in regard to this important fact and taught the necessity of seeking advice immediately after the first sign of a neoplasm."

International Medical Annual, 1905. E. B. Treat & Co., N. Y. 620 pp. $3.00.

This, the twenty-third yearly issue of the Annual, covers the advances made in medicine in the preceding year The eminent contributors have compiled an epitone taht iscomplete, concise, accurate, scientific in conception, and practical in execution. The wise selections and conservative criticisms will be of great aid to readers in estimating relative values. Good schematic arrangement and especial attention to therapeutics render the volume convenient of reference and rich in suggestion to every practitioner. The bibliography under each subject is valuable.

C. S. O.

Gynaecology, Medical and Surgical Outline for Students and Practitioners, by Henry J. Garrigues, A. M., M. D. 46 pages, with 343 illustrations. Published by J. B. Lippencott Company.

This book though written particularly for a text-book, is well adapted for such general practitioners as desire to make themselves acquainted with the essentials of modern gyneacology.

Minor operations which the general practitioner is likely to undertake are described in detail, although the whole field of gynaecology is outlined. Much valuable information is detailed regarding the technique of modern methods of diagnosis and the instruments and appliances in common use are freely illustrated. The absence of unnecessary detail and the practical nature of the volume, should create an active demand for it.

F. B. T.

Studies in the Psychology of Sex. Vol. IV.: Sexual Selection in Man. By Havelock Ellis. Philadelphia; F. A. Davis Co. Uniform with previous volumes.

Vol. IV. **Sexual Selection in Man.** The fourth volume of this unique series on the development and characteristics of sex treats of the motives and stimuli of sexual selection. In this are considered the skin and tactile sense, odors, voice, vision, beauty, and racial characteristics in selection. A vast quantity of facts from widely different sources is here brought together for the first time.

Like the other volumes of the series, this book is extremely interesting and provocative of reflection. Our knowledge on many of these points is so limited and the efforts to systematize our facts so few, that the formal study of this subject may be said to be in its infancy. The author wisely does not attempt to draw farfetched conclusions, but has grouped his facts in attractive and logical style and has made a great step in advance in the way of bringing together these observations in so complete a manner.

Malformations of the Genital Organs of Women. By Ch. Debierre. Translated by J. H. C. Simes. 5¾x8¼ in.; 182 pages; 85 illustrations. Philadelphia, P. Blakiston's Son & Co., 1905. Cloth, $1.50 net.

This little book covers the anatomy, embryology and malformations of the female genital organs. While the subject, in itself, is of limited value, the book will be read with interest on account of the broad philosophical questions involved. Viewed from the standpoint of developmental and comparative anatomy, the pages will be found most instructive, for the facts have been clearly and logically set forth.

The literature which has been quoted in support of the facts is not as recent as one would wish, but, inasmuch as there has been little added recently to our knowledge of the main facts in the embryology of the genital tract, this is perhaps a minor point. Errors are not wholly absent but the good points far outnumber those which can be criticised.

The Development of the Human Body. A Manual of Human Embryology. By J. Playfair McMurrich, A. M., Ph. D., Professor of Anatomy in the University of Michigan. Second edition; illustrated. Philadelphia. P. Blakiston's Son & Co., 1904.

The author of this volume, of which a second edition has been called for so quickly, is well-known in his university as a fascinating lecturer. Teaching a subject which can easily be made a dry and terrible grind to students, his lectures are followed with great interest by his classes and it is not unusual for his hearers to break into spontaneous applause at the close of a particularly able lecture. The faculty of stating the essential facts clearly and so grouping them as to bring out their mutual significance he has shown also in his text-book. The volume contains nearly three hundred illustrations, of which nearly all are excellent. The subject matter consists of lucid and well-knit chapters on the development of the various systems and regions of the human body with many and valuable references to comparative anatomy. A short bibliographical list of the more important sources follows each chapter.

The volume fills an important place, being the best suited to the needs of a student of medicine, of all the text-books on the subject with which we are acquainted, as well as an exceedingly convenient book of reference for the practitioner.

Practical Medicine Year Books. Vol. 1—General Medicine, by Billings and Salisbury. Vol. ii—General Surgery, by J. B. Murphy. The Year-Book Publishers, Chicago.

Vol. I. **General Medicine.** Frank Billings and J. H. Salisbury.

The first volume of this series for the new year comes to us more pleasing and valuable than before. If the whole series maintains the standard of this volume for interest and value, it will be excellent indeed.

As we have said before, the plan of these books is based on a correct understanding of the needs of the practitioner. Each subject has a volume by itself, so that the internist or obstetrician does not buy anything else than a review of his own subject ,if he so choose. There are no illustrations and the plan of reviewing the important literature on a subject for the year past is consistently adhered to. Dr. Billings' editorial comments are always pointed and valuable. Nothing superficial or "fussy" in the way of medical literature receives any attention at all, and every page is of interest. The chapter on tuberculosis is particularly good. We can sincerely recommend the volume.

Vol. II. **General Surgery.** By John B. Murphy. This volume contains over five hundred pages and must cover quite completely the best surgical contributions of the year. We notice but few reviews from foreign journals, but the limits of space may preclude this. The style is brisk and extremely interesting. One here gets a fuller appreciation of the vast amount of surgery done annually in this country. The editor gives full reviews of two important articles contributed during the year by himself, one of a series of operations on the prostate, and a very interesting and successful operated case of ertopiae vesicae in a male. The volume is sparingly but well illustrated, and fully deserves its important place in this most excellent series of reviews.

Progressive Medicine, Vol. I, March, 1905. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M. D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, 298 pages, 10 engravings and a full-page plate. Per annum, in four cloth-bound volumes, $9.00; in paper binding, $6.00, carriage paid to any address. Lea Brothers & Co., Publishers, Philadelphia and New York.

The March number of this invaluable resume of medical progress is devoted to the surgery of the head, neck and throat, infectious diseases including pneumonia, rheumatism and influenza, the diseases of children and the affections of the ear, nose and throat. The busy practitioner needs just such a synopsis as this to keep in touch with the world's progress along all medical lines, for few of us find time to read, much less to digest current medical literature. In the present volume Chas. H. Frazier covers well the remote consequences of head injuries, the diagnosis and surgical treatment of brain tumors, the lesions of the cranial nerves, the surgical treatment of goitres, with many other subjects.

Robt. B. Preble reviews the advance in knowledge of infectious disease with special reference to epidemic meningitis, rheumatism and pneumonia.

Floyd M. Crandall writes on diseases of children, the pages devoted to infant feeding and infant foods being especially worth reading.

In the chapter contributed by Chas. P. Grayson, the serum treatment of hay fever and intertracheal injections are timely subjects.

Robt. L. Randolph draws special attention to disease of the mastoid and middle ear. The entire volume is replete with valuable suggestions for the active practitioner.

F. B. T.

Conservative Gynecology and Electro-Therapeutics, by J. Betton Massey, M. D. Fourth edition, revised, rewritten and greatly enlarged. 6½x9½ inches; 467 pages; 157 illustrations. F. A. Davis Company, Philadelphia, 1905.

The first edition of this work appeared in 1898. It covers a field different from that of any other work and has rapidly passed through two other editions. The present, fourth edition, has been greatly increased in size and contains much new matter. Four entirely new chapters on the treatmnt of cancer by electro-chemical destruction and sterilization have been added, as well as a number of pages on the use of the Roentgen rays.

Three hundred and six pages are given up to the consideration of gynecologic affections, the treatment recommended being in practically every case non-surgical with much emphasis on electricity in its various forms. Illustrative cases are given throughout the text. Fifty pages are given up to the Apostolic treatment of uterine fibroids and a table of 110 cases, thus treated, is appended. The results are far from convincing, as are those of the treatment, by electricity, of extrauterine pregnancy.

That the teaching relating to the destruction of carcinomata by cataphoresis is dangerous and based on unsound pathology, may be judged by the following sentence: "The axilla may not be invaded (by the operator) at this time, if no signs of indurated glands be found." Experience has demonstrated, time and again, that freedom from induration is no criterion of freedom from carcinomatous involvement. In recurrent or "inoperable" cases, this treatment may be of value.

The remainder of the book is devoted to the cosmetic applications of electricity and to the rudiments of medical electricity. Its chief value rests in the excellent chapters on the physics, control and handling of direct and indirect currents and the uses of static electricity and the Roentgen rays.

The volume is well illustrated and the press work is excellent.

B. R. S.

Appendicitis. By John B. Deaver, M. D., Surgeon-in-chief to the German Hospital, Philadelphia. Third edition, thoroughly revised and enlarged. 6½x10 inches. 492 pages; 64 full page plates. Philadelphia, P. Blakiston's Son & Co., 1905.

The new edition of Deaver's Appendicitis is beautifully printed and bound, making a very handsome volume. One picks it up with pleasure and readily becomes absorbed in the contents, for the facts are so interestingly and simply set forth that it makes very easy and delightful reading. One feels the author's personality throughout and can not but appreciate that he speaks with authority, for few surgeons have had a greater experience with appendicitis than has Deaver. This new edition is based upon 3,000 cases.

The work opens with a history of the disease. The first authentic removal of the human appendix, during life, was by Amyand, in 1735. In 1848, Hancock performed the first deliberate laparotomy for peri-appendicular suppuration. In 1884, Kroenlein first removed the appendix for acute disease and Treves, in 1888, did the first "interval" opration.

Th plates illustrating the anatomy are excellent. Physiology, etiology and pathology are covered in a thorough and interesting manner. The author divides acute appendicitis into catarrhal, interstitial, ulcerative and gangrenous and the chronic, into catarrhal, interstitial and obliterating. The symptomatology, fully discussed, is summed up as follows:

There is no constant relationship between the symptomatology and the pathological alterations.

Of acute appendicitis there are three cardinal symptoms—pain, tenderness and rigidity of the abdominal wall.

The pain usually develops after eating. At first it is colicky and is referred to the epigastrium; later, it becomes localized at the site of the appendix.

Tenderness on pressure is always present.

The rigidity of the abdominal wall is usually right sided.

Vomiting is common at the onset of the attack. It desists in favorable cases. Its continuance is an unfavorable symptom.

In chronic appendicitis, the history is important. Localized pain and tenderness are the most constant symptoms. Palpation is a most valuable means of diagnosis.

The differential diagnosis is covered in great detail and a special chapter is devoted to the blood count. These sctions are especially valuable to the practitioner.

The author has always been a keen advocate of early operation and has seen the opposition with which he met in the earlier years gradually disappear. Full directions for carrying out the medicinal treatment are given, but are to be employed only when, for any reason, prompt surgical interference is impossible. The plates illustrating the operation and the accompanying text are excellent.

The book is one to be strongly recommended and should be read by every practitioner both of medicine and surgery.

B. R. S.

RECEIVED:

(Grateful acknowledgement of the receipt of the following is hereby made. Further notice in our review column may be given).

Fourteenth Annual Report of the Ohio Hospital for Epileptics, Galliopolis. A. P. Ohlmacher, M. D., Superintendent, 1905.

Two Cases Presented to the Clinical Society of the N. Y. Post-Graduate Medical School and Society.

1. **Multiple Herniae and Angioma Hypertrophicum.**
2. **A Case of Extensive Carcinoma of Tongue and Neck, Presenting Points of Special Interest.** By Wm. Seaman Bainbridge, M. S., M. D., New York. Reprints.

A Handbook of Nursing. Published under the direction of the Connecticut Training School for Nurses, New Haven. Philadelphia: J. B. Lippincott Co., 1905.

Program of Seventh Annual Meeting of the American Proctologic Society, Pittsburg, May 5-6. A. B. Cooke, M. D., Secretary, Nashville, Tenn.

Alling & Griffin's Diseases of the Eye and Ear. In Lea's Series of Medical Epitomes. Lea Bros. & Co., New York.

Program of Sixth Annual Meeting of the American Therapeutic Society. Philadelphia, May 4-5-6. Noble P. Barnes, M. D., Washington, D. C., Secretary.

Thirty-fifth Annual Report of the State Board of Health of Massachusetts. Boston, 1904.

The "Specific Therapy of Tuberculosis," by Charles Denison, A. M., M. D., Denver, Col. Reprint.

Some Points of View in Regard to the Time When to Perform the Myrnigotomy and the Mastoid Operation, by Emil Amberg, M. D., Detroit. Reprint.

Leukemia: The Ultimate Failure of the Roentgen Rays as a Therapeutic Agent, by Everett J. Brown, M. D., and Cecil M. Jack, M. D., Decatur, Ill. Reprint.

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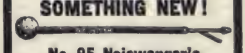

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See advertisement elsewhere in this issue of the Detroit Medical Journal.

Fifty Years in Business.

THE NEW IDEA, devoted to advances in pharmacy, gives up its last issue to a celebration of the completion of fifty years in business of Frederick Stearns & Co. It is a very interesting number. The tale of the growth of such a business as that firm is now doing makes fascinating reading. Ability, energy, perseverance, fair treatment, foresight, are here shown to have been the foundation of success, as they must always be. The firm is to be congratulated on their business success and the medical profession at large are to be congratulated in having a firm of such standing and repute with which to transact their business. z

An Eligible Combination.

A number of years ago Dr. James J. Sullivan (University Medical College), New York city, applied the remark, "An Eligible Combination" to a then new preparation of well known synergetic remedial agents. It is almost unnecessary to state that the preparation to which he referred is now well and favorably known as Antikamnia & codeine and 4¾ grains antikamnia. A fact which should not be overlooked, is that the codeine used in this tablet is specially prepared and purified, is non-constipating, and does not induce a habit. These are some of the particularly advantageous features of the Antikamnia Chemical Co's codeine and are well worth bearing in mind.

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Poulticing in the Army.

In a recent notification by the Surgeon-General of the U. S. Army, it is asserted that all the good results from poultices can be obtained in a more cleanly way by the use of the hot compresses. Hence the order to the army surgeons to drop linseed and linseed meal from army medical requirements.—Virginia Medical Semi-Monthly.

We highly approve of this order so far as discarding oultices, made of putrescible and bacteria-breeding materials is concerned, for that is what has been done by all up-to-date physicians in private practice, but we can hardly recommend the substitute offered. We supposed that every one in this enlightened age was using Antiphlogistine in all such cases, because of its advantages over everything else in permanency, efficiency and cleanliness. Compare Antiphlogistine, renewed but once a day, with hot compresses renewed every twenty minutes, and we cannot imagine any one using compresses when Antiphlogistine is available.

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Samuel E. Strong,
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we propose to proceed against all reputable manufacturers, importers and dealers, who infringe this patent

Other suits are pending against other infringers who have been selling either single or double neck tubes. Already preliminary injunctions have been granted against the following concerns:

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We have abundant facilities for supplying the trade and fill all orders promptly, and if you have any other tubes in stock not of our manufacture, we would suggest that you let us know at once, as we will undoubtedly hold every one responsible, who sells handles, or deals in Ethyl Chloride tubes which are not licensed by us.

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LISTERINE DERMATIC SOAP.—The Lambert Pharmacal Co. has lately inaugurated a new venture in the way of an antiseptic soap which possesses the virtues of Listerine in so far as a soap may. It is only a matter of recent years that especial attention has been given to producing soaps which shall possess a degree of curative power in diseases of the skin and in the care of surgical conditions. A considerable variety of such soaps is now on the market and the mission of the lot is wide; it is safe to say that Listerine Dermatic Soap will prove one of the most serviceable, and will soon make for itself a popularity with the profession in keeping with that which has been established by Listerine.—Medical Fortnightly, Jan. 25, 1905.

Quinine Without Ebriety.

When two such well-known drugs as antikamnia and quinine are offered to the profession it hardly seems necessary to indicate the special classes of affections which call for their use. Antikamnia is unquestionably a perfect substitute for morphine for internal administration. It has complete control over pain, while it is free from the undesirable after-effects of the alkaloid of opium. In cases of malarial fever the combination of antikamnia and quinine should be given as a prophylactic and cure. For all malarial conditions, quinine is the best remedy we have. But, associated with this condition, there is always more or less pain, and antikamnia will remove these unpleasant symptoms and place the system in the best condition for the quinine to do its work. There are a number of ailments, not closely defined, which are due to the presence of malarial poison. All such conditions are greatly benefited by the use of "Antikamnia & Quinine Tablets," each tablet containing 2½ gr. antikamnia and 2½ gr. sulph. quinine. The antikamnia in these tablets not only relieves the pain, but prevents the ebriety or ringing sensation produced when quinine is administered alone. In headache (hemi-crania), in the neuralgias occurring in anaemic patients who have malaral cachexia, and in a large number of affections more or less dependent upon this cachectic condition, the regular administration of these tablets is indicated.—Medical and Surgical News.

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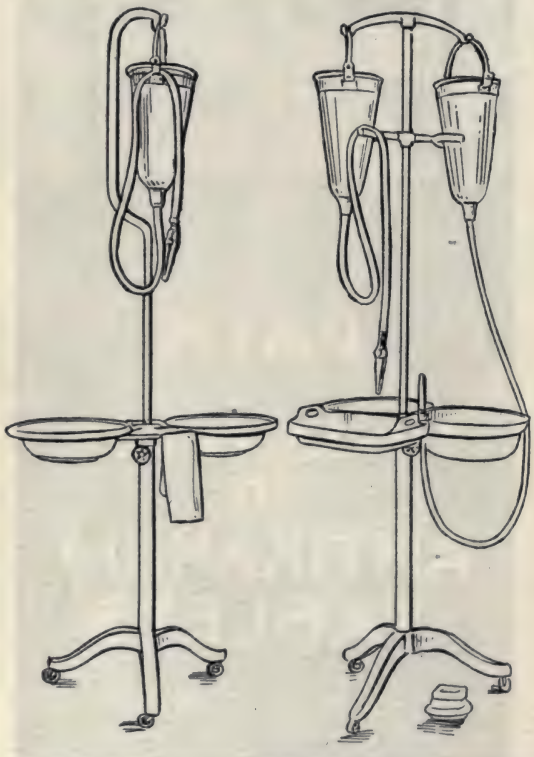

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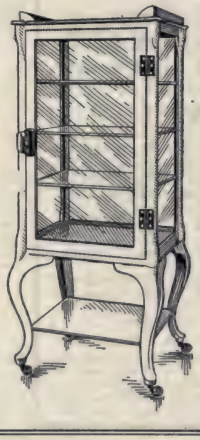

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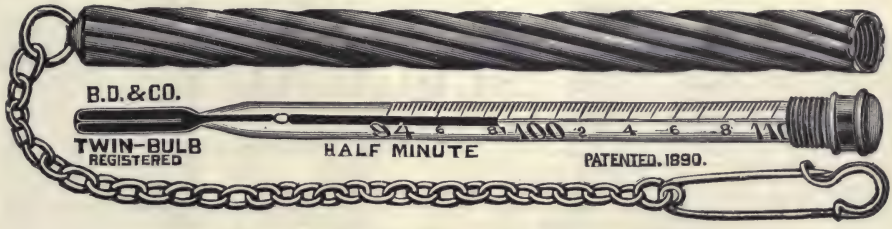

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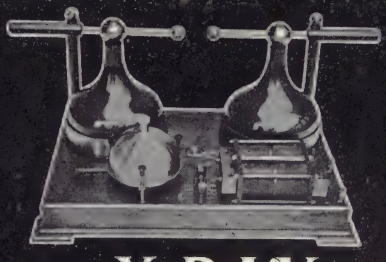

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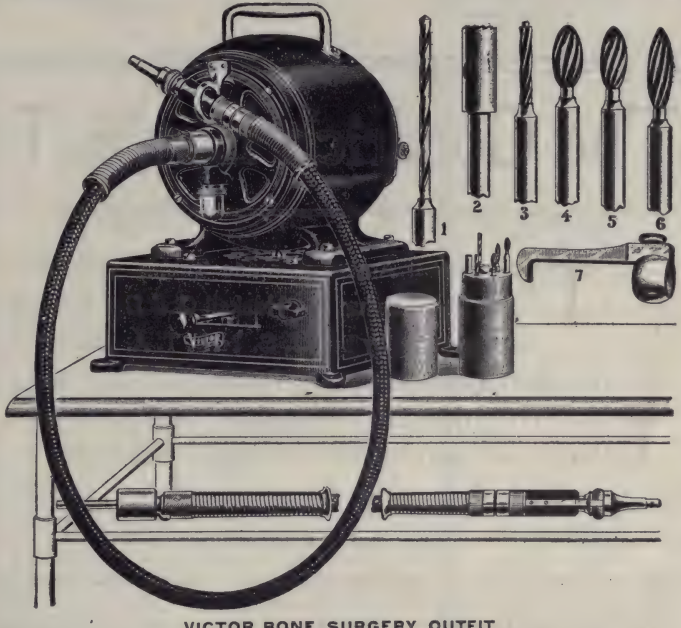

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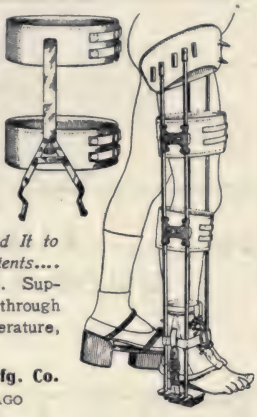

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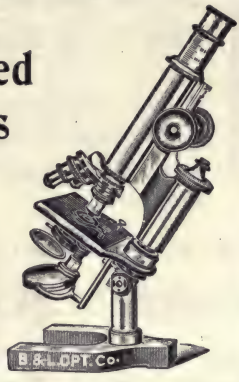

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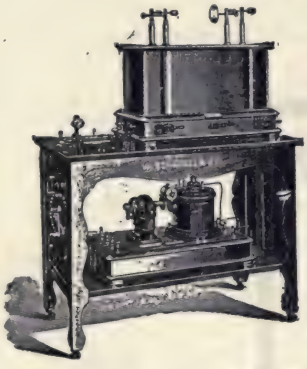

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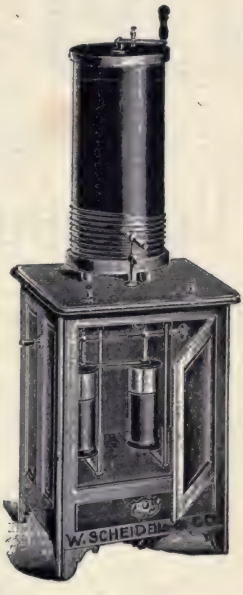

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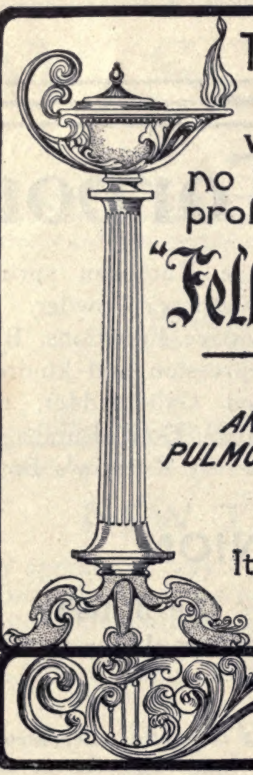

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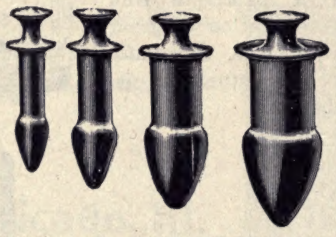

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